DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	5-11-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101433	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Dirteck, Singleton, Depo, CMS f.l., Roberts	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Brenda James

From: Jan Polatty
Sent: Wednesday, May 09, 2012 8:50 PM
To: Brenda James
Subject: Fw: Primary Care Bump Proposed Rule

Pls log

From: Anthony Keck
Sent: Wednesday, May 09, 2012 7:59:02 PM
To: Jan Polatty
Subject: Re: Primary Care Bump Proposed Rule

Yes.

From: Jan Polatty
Sent: Wednesday, May 09, 2012 6:27:39 PM
To: Anthony Keck
Subject: FW: Primary Care Bump Proposed Rule

Would you like me to log this for response?

From: Kathleen Nolan [mailto:kathleen.nolan@namd-us.org]
Sent: Wednesday, May 09, 2012 3:00 PM
To: Jan Polatty
Cc: Abby Kahn; Andrea Maresca; Matt Salo
Subject: Primary Care Bump Proposed Rule

HHS released their proposed rule around the primary care enhancement to be implemented Jan 1, 2013 (http://www.ofr.gov/OFRUpload/OFRData/2012-11421_PI.pdf). For two calendar years, primary care services will be paid at least at Medicare rates, with the additional amounts eligible for 100% federal match. The proposed regulation discusses several aspects of the payment enhancement process, including

1. What provider types are eligible and how that eligibility will be documented
2. Implementing the payment bump in managed care
3. The reporting requirements and program integrity elements, particularly as they relate to managed care implementation.

NAMD would appreciate your feedback on the regulation's ease of implementation, process requirements, and various formulas. Of particularly interest is the managed care requirements, and the steps for calculations of the FFP for MCO services under capitated payments. The comment period is 30 days from today. [NOTE: The NPRM includes new rates for Vaccine for Children, but that is a separate piece and not addressed here.]

Eligible providers (Sec 447.400)

- Eligible providers are those who can be designated as family medicine, general internal medicine, or pediatric practitioner. Sub-specialists are also eligible for the bump if they fall into these three categories (e.g., pediatric cardiologist, endocrinologist), but only for primary care service codes.

- States can use provider attestation, but must verify that they fit these categories of eligibility. Board certification in one of these three categories counts as verification.
- If the individual is not Board-certified, Medicaid should review claims records. Individuals whose previous year claims included at least 60% primary care codes qualify as eligible.
- The bump does NOT apply to services covered under FQHC and RHC payments.
- The bump applies to non-physicians providing the service under the eligible physician's supervision, as is currently typical.

States are currently not required to record or track board certification, so that may be a new classification and documentation process in states. We'd like to know how challenging it will be for you to verify eligible providers, board certified or not. Also, CMS is seeking comments on the 60% cut-off for non-board certified physicians.

Enhanced payments (sec 447.405)

- The regulation identifies which codes count as primary care for this purpose, and recognizes that there are more under Medicaid than under Medicare, primarily because of children.
- There are some Medicaid-specific services without a corresponding Medicare code and rate. For these, CMS will develop a fee schedule sometime before the implementation date of 1/1/13 (although no further timing is given).
- The codes include those for comprehensive primary and preventive care, counseling on behavioral change and risk reduction, periodic screenings and some non face-to-face services.
- The amount of the increase is the difference between the state Medicaid rate in effect as of July 1, 2009 and the Medicare rate in effect as of Jan 1, 2013 (with adjustments described below)
- Medicaid must use the geographic adjustments that Medicare uses, based on the location of the service delivery.
- Medicare rates are updated frequently, and states will have to accommodate those changes between the two years (2013 and 2014). However, within the calendar year, states can lock in an annual rate or adjust as changes occur.

Managed Care and the PCP bump (Sec 438.6 and 438.804)

- States will have to rework MCO contracts from several different angles, and will need to involve their actuaries in determining how to increase their rates.
- States must require MCOs to document primary care service delivery and demonstrate the increase is passed along to providers.
- For FFP purposes, States must analyze their 2009 capitation rates to determine the difference necessary to attain Medicare-level primary care rates. The regulation proposes a process by which states could identify the portion of the 2009 capitation that covered primary care, and then calculate the additional dollars needed to comply with Medicare rates.
- **If states can't substantiate a rationale for the capitation-to-Medicare rate conversion, they are not eligible for the federal match for MCO-delivered primary care.**

Process steps (447.410): [NOTE: No timeframes for submission on these various steps is given in the NPRM.]

- States will need to submit a SPA reflecting their fee schedule and adjustments process.
- Any managed care contracts must be revised and the revision and monitoring plan for passing bump to providers must be submitted to CMS.
- States would need to submit their methodology for identifying the incremental increase in the MCOs capitation attributable to going to Medicare rates.

Please send questions or comments to Kathleen Nolan (Kathleen.nolan@namd-us.org) or Andrea Maresca (andrea-maresca@namd-us.org).

Kathleen Nolan
Director of State Policy and Programs
National Association of Medicaid Directors
202-403-8622
kathleen.nolan@namd-us.org