
June 11, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2370-P
PO Box 8016
Baltimore, MD 21244-8010

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

To Whom It May Concern:

On behalf of the American Academy of Actuaries Medicaid Work Group,[1] I am submitting comments on the proposed rule regarding the Medicaid program and payments for services furnished by certain primary care physicians.

## Summary of the Proposed Rule

The Affordable Care Act (ACA), Section 1202, mandates increased payments for Medicaid primary care services in 2013 and 2014. Under the law, Medicaid fee-for-service (FFS) and managed care programs must reimburse primary care providers (PCPs) for these services at rates equal to Medicare. The federal government will provide a 100 percent match for this increase, which is intended to improve access to Medicaid primary care services in advance of the program's expansion in 2014. The proposed rule defines primary care services, eligible providers, and the applicable Medicare reimbursement rates. It also intends to provide guidance on calculating the rate differential for the purpose of claiming the 100 percent federal match. The proposed rule also updates interim regional maximum fees that providers can charge for the administration of pediatric vaccines under the Vaccines for Children (VFC) program. The VFC administration rates have actuarial implications in that, under the proposed rule, the difference between the updated rates and the 2009 rates may be funded at the 100 percent federal match under the rest of this proposed rule.

[1]The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

1850 M Street NW Suite 300 Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948 www.actuary.org

## Components of the Proposed Rule

In order for states to increase PCP payment rates and claim-enhanced federal funding, a state must ensure that:

- The provider is eligible for the increased payment;
- The primary care service codes are eligible;
- The state-plan and managed-care contracts have been amended appropriately;
- The differential in managed care rates between July 1, 2009, and calendar years 2013 and 2014 has been calculated appropriately and documented and approved by the Centers for Medicare & Medicaid Services (CMS).

## Managed Care Actuarial Soundness

It is vital that the program changes be calculated in an actuarially sound manner. Under the proposed rule, states will be required to implement managed care contracts for payment to a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to comply with the requirements in Section 1202 of the ACA.

## Comments/Questions

CMS requested comments on virtually all facets of the proposed rule. While there are substantial operational and implementation challenges with the FFS and VFC portions of the proposed rule, the comments and questions in this letter focus almost exclusively on the actuarial issues surrounding Medicaid managed care (with the sole exception of one question on VFC below). The page numbers mentioned in this letter refer to the document located here:

http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-11421.pdf

## VFC

Page 27682 of the proposed rule contains the following statement, "In addition, as stated in the October 1994 VFC notice, State Medicaid agencies would not be obligated to set the Medicaid payment for vaccine administration at the level of the maximum fees set forth in this proposed rule. Therefore, if these proposed maximum fees were to go into effect, the amount that a State pays a provider under the Medicaid program would not increase unless a State were to submit a State Plan Amendment (SPA) to CMS that increases the rate. In accordance with sections 1902(a)(30) and 1928(c)(2)(C)(ii) of the Act, States have the flexibility to set their payment rates at a lower level than the State's regional maximum fee." Although the wording seems very clear

on its face, it contrasts with language found elsewhere in the proposed rule requiring that VFC administrations be reimbursed at the Medicare rate. Please confirm that states retain this flexibility.

**Managed Care**

The proposed rule presents many challenging actuarial issues that need to be addressed. The Academy's Medicaid Work Group suggests that the Department of Health and Human Services (HHS) and CMS provide as much flexibility as possible to individual states as they submit for CMS approval the methodology they intend to use in identifying the increment to capitation payments attributable to the increased provider rates. This flexibility may include (but is not limited to) the following approaches specific to this program change:

- Full-risk prospective capitation;
- Prospective capitation with some type of risk-sharing that incorporates retrospective (actual-to-expected) reconciliation to documented expenditures; and
- Non-risk with retrospective (actual-to-expected) reconciliation to documented expenditures for any prefunding.

Yet another option might be for CMS to approve a methodology in which the state would pay the PCP increase to a capitated managed care plan in the form of a per-member per-month (PMPM) add-on payment based on a retrospective review of eligible primary care utilization. The plan would be obligated to pay the increase for applicable services provided. Structuring the increased payments as a bonus payment that would make the ultimate payment by service equivalent to 100 percent of the Medicare fee is another potential option.

In our opinion, this type of flexibility on managed care methodology is consistent with the wording on page 27676 of the proposed rule, "When making a payment, the State would have the choice of initially reimbursing a newly enrolled physician at the Medicare rate or the Medicaid State plan rate used for services provided by physicians who do not qualify for the increased payment. If the State chooses to reimburse a physician initially at the higher Medicare rate and later finds through the review of codes billed that the physician did not qualify, increased payments to which the provider was not entitled under the State plan would be considered as overpayments. Conversely, the State could choose to reimburse the newly enrolled physician at the Medicaid State plan rate applicable to services provided by physicians who do not qualify for increased payment, and then make supplemental payments promptly upon determining qualification for the increased payments."

**Claim Cost Component Actuarial Issues/Challenges**

The Medicaid Work Group appreciates that CMS has acknowledged some of the actuarial rating challenges within the body of the proposed rule. On page 27684, the proposed rule states, "The exact number of beneficiaries that will benefit is not known, however, we believe it will be substantial …" On page 27686 it states, "Therefore, currently it is not possible to accurately estimate the impact of these potential future changes since definitive action, if any, by the Congress regarding the MPFS CF is unknown." On page 27687, "Due to the limited data available, we are unable to accurately estimate the impacts representing the inclusion of services provided by practitioners under the supervision of a physician. All such services are billed under the supervising physician's billing number and are reported as physician services to CMS, making it impossible to determine the impact of this proposal."

For these reasons and because of additional challenges described elsewhere in this letter (as well as questions and concerns raised separately by states and health plans), providing states with methodology flexibility, from full-risk prospective capitation to non-risk arrangements, is of critical importance. With the multitude of actuarial pricing challenges involved, it is inevitable that actual experience will deviate from expectation—possibly to a significant degree. The Academy's reading of the proposed rule is that it is not intended to create health plan financial "winners" or "losers," but to increase access. If the adjustment methodology involves at-risk rate setting, however, winners and losers undoubtedly will result.

Below are several questions and comments that need to be addressed for a successful Jan. 1, 2013, implementation. The list is lengthy, but not exhaustive.

- When will states and health plans receive the needed Medicare physician fee schedule (MPFS) rates and the fee schedule for services reimbursed by Medicaid but not Medicare? The CMS-developed fee schedule is to be provided "prior to the beginning of CYs 2013 and 2014" and the 2013 Medicare rates may not be out until Nov. 1, 2012. Medicaid capitation rate and contract approval, however, typically is submitted to CMS 90 days before the effective date of the contract (in this case, Oct. 1, 2012).

- The impact of the proposed rule on capitated and subcapitated payment arrangements with providers could be substantial. The proposed rule as written could lead to or require a transition away from such capitation arrangements between health plans and providers. CMS states that it will not require plans to make changes to reimbursement arrangements other than to implement the fee increase. But it requires states to develop methodologies for identifying differential payment and estimating the increased amounts paid as of July 1, 2009, based on managed care data. This will be difficult to accomplish if primary care providers are subcapitated and encounter data that are not robust.

- It appears that rate adjustments will need to be plan-specific to claim the enhanced FFP. Because some health plans rely heavily on federally qualified health centers/regional health centers, that are not subject to the 100 percent rule, plan-specific adjustments would seem appropriate. If so, this will affect rate-setting methodologies that utilize county, regional, or statewide approaches. The use of diagnostic and/or pharmacy-based risk adjustment models to enhance the matching of payment to risk may present an additional challenge in assisting an individual health plan to pay the appropriate increase.

- For populations that moved from FFS to managed care between 2009 and 2013, how would states determine the increase to health plan capitation rates?

- Utilization per member may increase above baseline levels due to:

  1. Existing network providers providing more services, given the higher reimbursement rate;

  2. Potentially, new providers signing up with the network and providing additional services.

  There may be intended or unintended rating impacts to other service categories (such as pharmacy, hospital inpatient, physician specialist, emergency room, etc.) either in changed utilization, unit cost, or both.

- Physicians who bill under more than one identifier will need to be handled carefully. Separate information on both IDs would be necessary if the physician receives differing rates based on the ID used.

- Since many health plan contracts currently are paid as a multiple of the Medicaid rate, consideration must be given to health plans being forced to pay a multiple of the Medicare rate when it becomes the new Medicaid rate for applicable primary care services. For example, a health plan pays at 110 percent of Medicaid according to its contract. With a changed Medicaid fee schedule that equals the Medicare fee schedule, the health plan would have to pay 110 percent of the Medicare fee schedule.

- How will pay-for-quality, pay-for-performance, or other additional payments be viewed within the payment structure? If these payments raise the PCP's payment level to 100 percent of Medicare or above, does that suffice as complete payment? Does it apply as complete payment if those additional payments apply, or reasonably could be allocated to the applicable primary care services codes?

- If the intent is to have incentives that make the payment 100 percent of Medicare but the provider does not meet the goal and does not earn the incentive, how should it be accounted for (either for the 2009 reference point or for future reconciliations)? More guidance on non-ACA incentives is necessary.

- In Section 447.415(b) of the proposed rule, it states that, "For purposes of calculating the payment that would have been made under the approved State plan in effect on July 1, 2009, the State must consider all supplemental and increased payments made for the individually billed codes…" If the health plans have been making all of the payments—as they are in certain states—the state will not know what sort of incentive or supplemental payments were made to the providers.

- It is implicit that the additional funds associated with increased capitation payment for primary care services would not be affected by health plan bonuses or quality withhold arrangements, but this should be stated explicitly. States should carve these dollars out of any health plan quality or bonus withhold calculations since it is the intent of HHS and CMS that these increased payments flow freely to applicable primary care providers.

**Non-Claim Cost Load Component Actuarial Issues/Challenges**

The program change may affect many other managed care premium rate non-claim cost-load components beyond the medical claim cost component. To the extent they are affected, the following also should be matched at 100 percent:

- Administrative expenses that generally are expressed as a percentage of premium or—at least—as a percentage of claim dollars. Administrative expenses resulting from the change are significant and depend in part on any additional duties required, such as verifying provider eligibility prior to making an increased payment via board certification status, or review of billing history (60 percent threshold).

- Underwriting gain that is a component in covering the cost of capital at risk in the insurance operation, generally calculated as a percentage of premium.

- Premium-related taxes or quality assessments/fees imposed by states that generally are collected as a percentage of premium.

- The Federal Health Insurer Fee, which will be collected as a percentage of premium in 2014 based on 2013 market share and includes some Managed Care Organizations (MCOs) with Medicaid business but excludes some not-for-profit MCOs.

**Miscellaneous Comments/Questions**

Is it implied on pages 27678 and 27684 of the proposed rule, (reporting requirements/documentation by the MCOs) that this documentation will be required for states to claim 100 percent FFP? Is 100 percent FFP based on actual reported/documented expenditures, or

based on the actuarial PMPM assumptions built into the adjusted capitation rates (including non-claim components discussed above) as a result of the change?

The calculation on page 27679 of the proposed rule appears to be flawed. The $16.67 is a PMPM. It is unclear why this amount would be compared to a Medicare fee. Should the example be: "Assume a $25 per visit Medicaid rate. Assume a $40 per visit Medicare rate. With the stated eight visits annually, the annual amount needed to fund the claim cost component of the change is ($40 - $25) x 8 = $15 x 8 = $120 per year or $10 per month for this one individual."

Per page 27683 of the proposed rule, are states required to submit their methodology for determining the rate differential for managed care payments to CMS for approval six months prior to the beginning of 2013 (meaning by June 30, 2012)? This appears to be inconsistent with statements elsewhere in the proposed rule that require states to submit their methodology to CMS before the beginning of 2013. In other words, CMS may wish to clarify whether the methodology should be submitted to CMS either "six months prior to the beginning of 2013" or at any time in 2012.

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The work group welcomes the opportunity to speak with you about any of the items discussed in this letter. If you have any questions, contact Tim Mahony, the Academy's state health policy analyst (202-223-8196, Mahony@actuary.org).

Sincerely,

Michael E. Nordstrom, ASA, MAAA
Chairperson, Medicaid Work Group
American Academy of Actuaries