June 11, 2012

Marilyn Tavenner  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

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 nation’s Medicaid directors, the National Association of Medicaid Directors (NAMD) submits comments on the proposed regulation, “Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program.” We appreciate the opportunity to provide recommendations that we believe will help clarify and ease the implementation of the required increases in Medicaid primary care services rendered during calendar years 2013 and 2014.

The concept of increasing state Medicaid program primary care reimbursement rates to at least the Medicare level will, along with other factors, assist in state efforts to successfully increase access to primary care services. Unfortunately, as the rules are proposed, implementation will be administratively burdensome, complex, costly, and may jeopardize timely implementation and place at risk the intended outcome.

Medicaid Directors respectfully urge CMS to revise the proposed rule to incorporate our recommendations to simplify implementation processes, improve transparency of the applicability of the rate increase to providers, and minimize the administrative burden to states for implementing the requirements as proposed. Medicaid Directors also urge our federal partners to work with states to clarify and resolve the outstanding issues identified herein and ensure consistency with congressional intent. It is imperative that CMS allow states as much flexibility as possible in implementation of the time-limited enhanced payment.
Our comments center on two overarching themes:

1) States must develop and implement the policies and procedures to comply with the provisions implementing the new statutory requirements. However, Medicaid Directors believe the proposed rule is overly complex from an operational perspective. This threatens to impede states’ ability to implement the enhanced payment for providers by the January 1, 2013 implementation date and, in some states, could make implementation entirely unworkable.

2) The application of the higher reimbursement rate is at the same time overly narrow and too expansive. Medicaid Directors believe that CMS should amend its framework, and, to the greatest extent possible, grant states the flexibility to target the higher payment to providers designated as the primary care provider.

**Payments to Physicians for Primary Care Services: Statutory and Regulatory Framework**

The Preamble states that it is critical that a sufficient number of primary care physicians participate in the Medicaid program. The Preamble goes on to state that the primary care increase will encourage primary care physicians to participate in Medicaid by increasing payment rates. While Medicaid Directors agree that physician participation in the program is critical, we also believe that reimbursement rates are one of a number of significant factors impacting physician participation in the Medicaid program. Other issues driving the level of participating physicians include the overall supply of physicians within a particular geographic region or state, and medical students’ decisions to specialize in a particular field, among other factors that are not unique to Medicaid.

Further, Medicaid Directors believe it is essential to look not only at the supply of primary care physicians, but also the demand for these services. Specifically, states seek to become more rational purchasers of care and to help educate Medicaid clients to ensure appropriate utilization of services from the most appropriate provider. States have and will continue to undertake innovative approaches to ensure there is sufficient provider supply, for example by utilizing physician extenders, implementing and expanding telehealth and telemedicine programs, and encouraging preventive measures and services.

States have focused efforts on ensuring that primary care providers are caring for Medicaid members, including through care coordination and integration initiatives like health homes that are supported by CMS. Similarly, CMS should reconsider its framework and ensure the higher reimbursement is targeted to the providers truly delivering primary care services. We have strong concerns that, as proposed, this rule is poised to create disincentives for delivery of primary care services by the most appropriate provider as well as for accessing primary care services in the most appropriate setting. Revision of this regulation is critical in order to ensure implementation does not inhibit
states’ efforts to facilitate use of the right providers and related initiatives to drive delivery of appropriate services in the most appropriate setting.

Implementation Timeframes and Operational Issues

As proposed, the rule establishes unnecessarily complex requirements and process for identifying eligible providers. In addition, the simultaneous complexity and vagueness of the process for implementation in managed care programs creates additional implementation challenges for states. In many states, it takes at least several months to implement the types of policy changes that CMS has proposed. Therefore, the complexity of the proposed rule will make it difficult if not impossible for many states to meet the January 1, 2013, implementation date. Further, we believe several states may not be ineligible for the increased FMAP because of changes in their reimbursement rates since July 1, 2009.

Therefore, we urge CMS to grant all states greater flexibility to implement these payment provisions in a manner that is fiscally sound and best addresses the needs of Medicaid members. For example, we request that CMS work with states to allow for implementation in phases if needed and to allow states to make retrospective adjustments.

Payments to Physicians for Primary Care Services

Section 1902(a)(13)(C)) of the Social Security Act specifies that physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine are primary care providers. Those that render evaluation and management codes and services related to immunization administration for vaccines and toxoids for specified codes also would be eligible for reimbursement.

As proposed, in order to be eligible for the increased payment the following requirements must be met. The provider must:

- Be a physician, or under the personal supervision of a physician, with a specialist designation of family practice, general internal medicine and pediatric medicine or a subspecialists related to one of these primary care specialists and recognized by the American Board of Medical Specialties; and
- Be board certified in the specialty or subspecialty; or
- Have furnished evaluation and management (E&M) and vaccines services that equal at least 60 percent of the Medicaid codes billed during the most recently completed calendar year.
There are a number of operational challenges and significant new administrative burdens associated with the proposed method for designating an eligible provider. For example, we note that few states currently maintain up-to-date certification records. Nor are all state’s provider records tied to some other state database that tracks up-to-date board certification information. Further, reviewing provider files for the 60 percent service requirement adds an additional administrative task not currently required of the states. Additionally, states will need to implement a process to reimburse newly enrolled non-certified providers at a higher rate which will require additional, new administrative tasks and processes to assure the integrity of state Medicaid programs.

Implementation of this provision will require most states to invest significant time researching and reviewing provider records and claims. This could significantly slow

Therefore, NAMD respectfully requests that CMS adopt the following recommendations related to provider designation:

1) Provide states the flexibility to apply the provider rate increase leveraging states’ existing enrollment and claims processing capacity.

2) The process for reimbursement of new physicians also is problematic and results in system costs and administrative complications. We recommend that states continue to rely on the provider’s reported specialty and existing system capacity.

3) CMS should adopt an alternative approach in which the non-board certified physician would qualify if she/he completed an approved residency in one of the three designated primary care physician fields.

4) Since taxonomy is used as an indicator for specialty and subspecialty and is self-reported, NAMD recommends that states be given the flexibility to use taxonomy for confirmation of specialty and that no additional verification process be imposed on states. The imposition of the proposed requirement results in significant changes to systems and provider enrollment processes, is administratively burdensome and costly to implement, and could adversely impact operational timelines.

5) Board certification is not confirmed at a national level in the assignment of taxonomy and National Provider Identification (NPI). Therefore, states should not be required to confirm this at the state level. Instead, states should be permitted to rely on CMS assignments of NPI taxonomy.

Specified Specialists and Subspecialists. As proposed, the rule would allow subspecialists related to the primary care specialists designated in the statute to qualify for the higher
payment if they are recognized by the American Board of Medical Specialties (ABMS). We believe that this proposal would add 44 additional specialty designations to the list of physicians who are eligible to receive the increased payment rate. Included among eligible providers are physicians who practice sports medicine and sleep medicine. However, OB/GYNS and psychiatrists, both of which bill evaluation and management (E&M) codes that are equated with the provision of primary care, are not included in ABMS’ listing.

This proposal could incentivize inappropriate behavior by certain providers. Further, the breadth of this proposal threatens states’ ability to meet the statutory requirements of 1902(a)(30)(A), which require assurances that payments under the state plan are consistent with economy, efficiency and quality of care. In other words, this broad proposal would require higher payments to specialists without a rational correlation to the subspecialists that do – or that might as a result of the temporary higher payment – deliver primary care services to Medicaid members. The proposal also does not provide reasonable assurances that extension to a broad array of subspecialists will expand access to primary care services.

In addition, we believe the proposal significantly expands the number of eligible physicians beyond a reasonable interpretation of the statute. In turn, as proposed, the extension to a wide range of subspecialists will have considerable budgetary impacts for most states, including those that adjusted their reimbursement rates downward since 2009. Further, the broader provider categories (internal medicine, family practice, and pediatrics) should continue to apply as states currently have different enrollment and claims processing capacity and may not be able to identify all provider subspecialties and reimburse a different rate by subspecialty.

As noted earlier, states seek to support the delivery of primary care by the most appropriate provider in the most appropriate setting. Further, states, rather than federal agencies, are in the best position to make this assessment for their Medicaid members. For these reasons, we strongly urge CMS to rescind this provision and consider other proposals contained herein for creating a more flexible framework for states to identify eligible primary care physicians.

60 percent threshold. In the Preamble to the proposed rule, CMS noted the 60 percent service requirement is designed to align Medicaid with the statutory requirements for the Medicare Incentive Payments for Primary Care Services authorized by section 5501(a) of the ACA, which amended Section 1833 of the SSA that specifically requires that primary care services account for at least 60 percent of the allowed charges billed by a practitioner for services to be eligible for increased payment. Medicaid Directors do not agree that it is appropriate to designate a threshold. We believe that if Congress had sought to align the two payment provisions, it would have included the language in Section 1833 in the corresponding provision in Medicaid law.
Furthermore it is worth noting that the Medicare provision under 1833 is labeled an “incentive” and provides for a 10 percent increase in payment. NAMD notes that there is no performance target associated with the Medicaid increase; Congress established a minimum payment as specified in the newly created section of 447.405. As such, to require 60 percent does not appear to align with the provision.

Finally, the requirement for states to review billing histories of each provider would result in tremendous, unanticipated administrative burdens, especially with respect to newly enrolled providers without a Medicaid billing history.

Again, to alleviate the administrative burden and align with existing regulatory language, NAMD recommends that states be allowed to accept physician self-designation of specialty as permitted by Medicare or rely on current systems such as enrollment as a primary care provider (PCP) in the state's Medicaid program. This would help reduce administrative burden and ensure that physicians that have historically provided evaluation and management services are eligible for the increased rate.

**Specified Physicians**

The proposed rule states that primary care services would be paid at the higher Medicare rate if properly billed under the provider number of an eligible physician, regardless of whether the service is furnished by the physician directly or under the physician’s personal supervision. This approach could recognize the important role that non-physician providers working under the supervision of physicians have in delivery of primary care services.

However, in proposing to do so, CMS should consider that many states have billing and oversight policies and procedures designed to elicit desirable policy goals or analyses, but which also will make it administratively difficult for non-physician providers to receive the higher Medicare rate. For example, some states require certain non-physician providers to obtain their own billing number. This can allow Medicaid programs to conduct more detailed analysis and monitoring of physician supply and the provision of primary care services to Medicaid clients. Given the temporary nature of the increase, states may determine that changes to Medicaid systems and states’ policies to accommodate the pass-through of the reimbursement increase may not be cost effective. Further, such changes could obscure who is delivering primary care services, which in turn could disrupt state planning on a range of issues.

*Obstetrician/Gynecologist.* Obstetrician/gynecologists is not identified as a board certification category for recognition as eligible providers. Yet they are an integral part of
health care delivery in Medicaid, often serving as the designated primary care physician of record. NAMD requests that CMS reconsider this category of providers for inclusion in this program on terms similar to other physician types.

*Crossover claims.* The rule proposes that the increase in primary care payment will also be provided for Medicare/Medicaid cross over claims for dually eligible members. This poses significant administrative challenges in state Medicaid fee-for-service and managed care programs. States are responsible for any wrap-around payments that CMS will not cover with respect to these individuals.

However, in many states providers frequently do not bill the state or Medicaid managed care plan if they know the reimbursement initially received from Medicare exceeds the Medicaid fee schedule. For providers not in a state’s fee-for-service program or managed care system, a state will not know whether or not the claim truly represents a service delivered by a provider functioning as a primary care physician, nor will a state necessarily have access to detailed information regarding board certification or eligibility.

States need either encounter data for these beneficiaries or significant flexibility in determining increased payments to managed care plans related to dually eligible beneficiaries – particularly for sub-capitated arrangements. One possible solution we recommend that CMS consider is for the federal agency to provide a file to states that identifies physicians eligible for the payment increase on cross over claims. Alternately, CMS could administer claims for this dually eligible population entirely by paying 100 percent through Medicare for the services and providers that qualify.

**Minimum Payment**

The proposed rule provides for minimum payment levels for E&M codes and vaccine administration.

*Medicare Physician Fee Schedule (MPFS).* The Preamble to the regulation notes that while the Medicare rates may be updated throughout a calendar year, states have the ability to either adopt annual rates or use a methodology to update rates to reflect changes made by Medicare during the year. We also note that CMS typically releases the physician relative value units (RVU) file late in the calendar year – likely too late for states to incorporate the Medicare payment rates on January 1, 2013. Many states would then most likely initiate the process using the prior year's rates, re-configure pricing to make a mid-year correction and adjust prior claims. This is a complicated multi-step process and states are also concerned that there will not be enough time once the final rule is published to finalize a methodology, develop rates, update contracts, and obtain CMS approvals prior to January 1, 2013.
States will need the flexibility to implement changes retrospectively given these timing challenges. Medicaid Directors support the proposal to allow states to adopt either annual rates or a model that best suits a state’s current practice. For example, one potential model should allow states to develop an average Medicare rate, as opposed to applying facility differentials and geographical conversions in the rate setting and claims adjudication process. States would update the rate as changes to the Medicare rate impact the average. This flexibility will allow states to align the implementation with other scheduled activities and should be included as part of the State Plan Amendment (SPA) submission.

Geographic location and site of service. The proposed rule specifies use of the Medicare Part B rate that is applicable to the site of service and geographic location of the service. States that use a statewide fee schedule regardless of geography and/or site would be required to obtain information regarding both and edit systems accordingly.

However, Medicaid reimbursement systems generally do not apply facility differentials and geographical conversions in the rates and claims adjudication process. Imposition of this requirement will result in making significant changes to the MMIS. This will result in increasing cost to the states and federal government for a change that will be in place for a limited amount of time and may impact implementation timelines. Therefore NAMD requests that CMS allow each state to apply the rate increase based on existing claims processing capacity and available data rather than limiting it to the rate that is applicable to the site of service and geographic location of the service. As previously discussed, we also recommend that CMS consider allowing states to develop an average Medicare rate, as opposed to applying facility differentials and geographical conversions in the rate setting and claims adjudication process.

Eligibility for 100 percent Federal Financial Participation

The proposed regulation specifies that 100 percent FMAP would be available for the amount by which the established Medicare Part B payment exceeds the Medicaid payment that would have been made under the approved State Plan in effect on July 1, 2009. These provisions apply to fee-for-services payments and managed care.

The proposed rule specifies a range of procedure codes that are identified as “primary care services.” Section 447.410 requires that a state amend its plan to reflect the increase in fee schedule payments for each of the eligible billing codes. Many states have identified evaluation and management (E&M) codes within the range of specified codes that are not currently covered within the state Medicaid plan. NAMD requests that CMS clarify that the federal agency is not requiring that all codes be covered. Instead, we seek
confirmation that CMS is maintaining the authority for states to continue to reimburse providers at the higher level only for services eligible under the state Medicaid program.

In addition, states request that CMS clarify the applicable Medicare rate for particular services that a state Medicaid program did not cover in 2009 but does cover in 2013 and 2014. That is, would the applicable rate be the greater of the Medicare rate in 2009, 2013, or 2014?

**Supplemental payments.** For purposes of determining the payment rate under the State Plan in effect on July 1, 2009, the rule proposes to require states to consider all supplemental and increased payments made for the individually billed codes, including any incentive payments and other supplemental payments in effect at that time. CMS also is proposing that states be required to use the Medicare Physician Fee Schedule (MPFS) as published. However, in determining the Medicare rate, the Preamble of the regulation noted that the Medicare primary care incentive payments made pursuant to section 5501 of the ACA, which amended section 1833 of the SSA, would not be included. Section 5501(a) provides for incentive payments for a subset of the codes covered by this regulation. The payments are not made as increases in fee schedule amounts and are not reflected in the MPFS.

Therefore, Medicaid Directors recommend that CMS apply similar logic to supplemental payments to the determination of the Medicaid rate since these payments are periodic, may only apply to a subset of codes, and may not include all providers. Otherwise it may be difficult for states to determine the appropriate basis for the payment differential.

Regarding Medicaid performance based payments and programs, states request that CMS apply similar logic as that it proposed for Medicare. That is, CMS should exclude “pay for performance” or similar types of supplemental payments in the determination of the applicable 2009 Medicaid reimbursement rate for the primary care service for the eligible physician. It would be significantly burdensome to both the providers and the State to determine what portion of the supplemental payment is just for those providers and services covered under this proposed rule.

**Submission of claims.** Eligible providers that render primary care services during CYs 2013 and 2014 will receive at least the applicable Medicare reimbursement rate. However, billing by such providers may not be processed for many months thereafter. We ask CMS to clarify that providers have no less than 12 months from date of SPA approval to file claims for payment. We also ask CMS to confirm that state Medicaid agencies will be allowed to claim the 100 percent federal participation until they have been reimbursed in total for whatever they have paid to eligible providers per the statutory requirements for the temporary higher rate during CYs 2013 and 2014.
In addition, we urge CMS to provide states flexibility in meeting these timelines as it relates to the increase given the short timeframes for developing verification plans, managed care methodologies, and state plans that CMS must subsequently approve and the systems changes required for implementation.

**Applicability to Managed Care Plans**

As noted, the rate increase applies to services by eligible providers participating with managed care plans. Specifically, the proposed regulation 42 CFR 438.6(c)(3)(v) and 438.6(5)(vi) require managed care contracts to comply with new minimum payment levels, make those payments to physicians (whether directly or through a capitation rate), and provide documentation to the state regarding the payment increases.

The regulation also creates 42 CFR 438.804, which specifies that 100 percent federal financial participation (FFP) is available for the portion of the expenditures for capitation payments made under those contracts that comply with contractual requirements under 438.6(c)(50)(vi) only if the following requirements are met:

1. The State makes a reasonable estimate of the increased amounts paid for specified primary care services provided by eligible primary care physicians resulting from contractual requirements under 438.6(c)(5)(vi), based on information received from the managed care provider for services furnished as of July 1, 2009.
2. The State develops a methodology for identifying the differential in payment between the provider payments that would have been made by the managed care provider on July 1, 2009, and the amount needed to comply with the contractual requirement under 438.6(c)(5)(vi).
3. The State submits the methodology in paragraph (a)(2) of this section to CMS for approval before the beginning of CY 2013.

**Determination of eligible physician.** As previously noted, the rule provides payment increases for a number of subspecialists in addition to primary care physicians. In most state managed care programs, a Medicaid member’s primary care provider is clearly identified and designated as such within the managed care system. Therefore, we recommend that states operating managed care systems be given flexibility to apply the increase in payment specifically to providers serving as the primary care physician within states’ managed care systems.

As noted above, the proposed rule also extends the payment increase to services provided by nurse practitioners and physician assistants when properly billed through an eligible physician. We recommend that states operating managed care systems be granted flexibility to apply the increases in payment specifically to those nurse practitioners and
physician assistants who are functioning as primary care providers within the states’ managed care systems.

**Increased payment methodologies.** NAMD requests that CMS simplify the requirements for states to receive 100 percent FFP as the proposed requirements are overly complex and will likely be difficult for many states to meet. Specifically, the regulation requires that the rate be based on information received from the managed care provider for services furnished as of July 1, 2009. We recommend that CMS add language that could states in determining the rate differential. Specifically, we request that CMS insert ‘or data used by the state in developing payment rates’ following “from the managed care provider” at 42 CFR 438.804(a)(1). NAMD also recommends that for states that implemented managed care after 2009, the regulation should clarify that it will be based on the FFS or base utilization data.

For those states operating managed care programs in 2009, the requirements may be problematic for several other reasons. The Preamble appears to indicate that the rate paid was included in the encounter data. While a state may have collected this information, it may not have been thoroughly validated for this purpose. Since states had no way of knowing this would be a condition of FFP, it will impose a significant burden, or could be impossible, for most states to obtain this historical data. For example, a data field for payment could include charge information or it could have been blank or not otherwise used. Assuming the data is available and retrievable, a state may have to amend its contracts with health plan entities to impose additional reporting requirements.

The proposed rule also requires states to include managed care organization reports for justification of increased capitations. The imposition of additional reporting requirements, if reports result in variation of capitation rates throughout the year, will be complicated and difficult to implement. We also note that the new special provision appears to conflict with 438.6(c)(3)(i) which requires that actuarially sound rates be based on utilization and cost data that are derived from the Medicaid population. The 2009 cost data included in the rate may not reflect the amount paid to the provider, since contracts are risk arrangements. We also note that this rule will be difficult to implement for physicians being paid a salary by the health plan entity because information may be confidential.

Given these challenges, NAMD recommends that states be given as much flexibility as possible in choosing the methods for determining the differential. That is, CMS should allow states to submit a methodology for claiming the enhanced FMAP associated with the increased capitation. Some of the possible methods states could use include the following:

- An actuarial sound cost accounting analysis where the enhanced FMAP for primary care payments is calculated based upon a historical cost accounting analysis of existing health plan data of the specific provider codes. This methodology is similar to
the enhanced claiming for family planning service expenditures that are a component of the capitation rate. Many states have experience with this methodology and could modify it to capture the expenditures related to the portion of the capitation payment attributable to the minimum payment.

- A “below the line” adjustment on a per member month basis indicating the enhanced funding amount for each contracting Medicaid health plan. Based upon the calculation, each plan would appropriately identify the amount of enhanced funding that will be passed onto eligible providers. This would be outside the risk structure of the contract.

*Volume of payment.* The Preamble notes that the increase in payment must correspond to the volume and increase in payment specified in the rule. It is presumed that the volume requirement is the 60 percent threshold established in the regulations. As noted above, this information is difficult to determine, and some states may not have access to this information.

With respect to rate development, NAMD believes it is unclear how the volume requirement would be addressed. Since 2009, states have had a tremendous increase in enrollment and utilization of services and implementation and expansion of managed care programs may not be captured in 2009 data. More importantly, the volume requirement does not appear to align with the statutory intent that E&M service rendered are paid at least the Medicare rate.

*Submission of methodology.* The regulation requires that the methodology must be submitted to CMS prior to CY 2013. However, given the uncertainty of when a final rule will be issued and the likely need to conduct additional rate-setting analysis to comply with the data, it is unlikely that any state could submit a methodology for CMS approval prior to then. Furthermore, since the state must comply with other rate-setting requirements in 436.6, it is unclear if the methodology is to be submitted separately from the rate certification or if it must be submitted with the rate certification. If the latter, it is unclear why the proposed regulation appears to require separate submissions.

Further, neither the Preamble nor the proposed rule provides any standards by which CMS will evaluate and approve or deny the methodologies. This creates further uncertainty regarding the submission process and timeframes. NAMD recommends that CMS seek additional state input into this process as the 30-day comment period provided for this rule was insufficient to provide comprehensive comments on this important aspect of the rule.

*Other affected managed care components.* NAMD requests that, to the extent the final rule increases the administrative burden on health plans, full federal funding should be made available for those administrative expenses. We also request that full federal funding
be made available for other rate components impacted by this increase, such as the Federal Health Insurer Fee, premium-related taxes, and underwriting gain.

State Plan Amendments

The rule requires states to amend their State Plan to reflect the increase in fee schedule payments for CYs 2013 and 2014 unless the state currently reimburses at least as much as the higher Medicare rate for the applicable period. We note that this requirement deviates from CMS’ usual process for the submission of a SPA, which is within the quarter in which the change is implemented, and we request that CMS consider allowing states more flexibility in the timeframe.

*State Plan Requirements.* States require additional information regarding the contents of the SPA, including any specific information states must provide with respect to assuring verification and identifying applicable rates, specifying any mid-year updates, and assuring notification and whether states must identify the actual CPT codes. Given the very short timeline to submit the SPA and implement the significant changes to state systems, NAMD respectfully requests that CMS work with states to clarify outstanding issues and provide these details in a timely manner. In addition, we recommend that CMS develop a SPA template that states may use. A SPA template could help facilitate timely and efficient implementation.

States also request that CMS allow the Medicaid agency to include an automatic sunset period in the SPA to reduce administrative burden for the state and federal partners at the conclusion of the period for the temporary reimbursement increase. This option will reduce the administrative burden for states and the federal agency at the conclusion of the statutory requirement for higher reimbursement.

*Payment Distributions.* It should be noted that the proposed regulation does not specifically detail the distribution of payments. NAMD requests that CMS clarify that states have the flexibility to make the increased payments either as part of the adjudication of the claims or as supplemental payments.

The law requires that states and managed care plans must comply with 1902(a)(37) regarding timeliness of claims payments. In order for the supplemental claims payment to also comply with the timely claims payment requirements, NAMD requests that for states that choose to provide supplemental payments, such states be granted the authority to approximate payment or provide such payments more frequently than quarterly.
Immunization Administration

For vaccine administration, the state must impute the payment that would have been made under the approved Medicaid State Plan in effect on July 1, 2009 by calculating the average payment for specified codes weighted by volume.

In determining the rate as of July 1, 2009, states will need to impute the CY 2009 rate for code 90460 based the average payment amount for the deleted codes weighted by service each of the four CY 2009 rates for vaccine administration multiplied by their respective percentages of service volume and then added to determine one payment amount. This is required as four CPT codes for immunization administration in 2009 were deleted and replaced with 90460 and 90461 (which is to be reimbursed at 0).

We recommend that CMS allow states to develop and propose a methodology for determining the 2009 vaccine administration rate and permit states to implement the rate change in accordance with states’ current payment policies related to the administration of vaccines.

Administration fee impact. In its discussion of the Vaccines for Children (VFC) program maximum administration fee, CMS notes that the amount paid to providers for administering vaccines to Medicaid-eligible children through state Medicaid programs will not increase unless a state elects to increase its rate by submitting a SPA. However, the Statement of Regulatory Impact indicates that providers who provide immunizations under the Medicaid program must be reimbursed at the lesser of the 2013 or 2014 Medicare rate, or the Regional Maximum VFC Administration Fee in 2013 and 2014. We request that CMS clarify the requirements related to reimbursement of Medicaid providers providing immunizations through the VFC program.

Regulatory Impact

Several states reviewed the proposed revisions and compared these to similar initiatives, such as 5010 implementation, to assess the relative administrative and financial burden on states. Based on assessments from a number of states, NAMD believes the regulatory impact statements significantly underestimate the time and resources for states to undertake the significant coding and related systems work, conduct the necessary analyses and develop policies, implement the regulation as part of regular operations, and maintain compliance with the regulation, as currently proposed. Therefore, we strongly urge our federal partners to engage states in further conversation to more accurately assess the impact and ways to minimize the multiple challenges.
On behalf of the nation’s Medicaid Directors, we thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work with CMS on these issues throughout this rulemaking process and beyond. If you have any questions regarding our comments or require additional information, please do not hesitate to contact Andrea Maresca, NAMD’s Director of Federal Policy and Strategy at andrea.maresca@namd-us.org.

Sincerely,

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