

**Date:** January 14, 2015

**Re:** SPA 15-003 (OPPS) and SPA 15-005 (RBRVS)

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**Comment #1 (Finance Director-Richford Health Center):**

We receive payments under the MAPCP for a small number of patients. Many people that we see do not, however, get attributed to us and we don't get the monthly PMPM payment. Does this mean that we can bill for those individuals or does this mean that because we participate in the demonstration that we cannot bill for any of these services regardless of them being an attributed patient?

**Response:** The proposal is not to reimburse for these codes under FFS given Vermont Medicaid's participation in the MAPCP and existing financial support for the care management services described by the new service codes under this program. We are finalizing our decision not to make a beneficiary level distinction so not to dis-incent participation in the MAPCP and increase operational costs and administrative burden of Medicaid operations. Improvements to patient attribution methodologies used in alternative payment models in Vermont including the one used in the MAPCP is a focus on the Vermont Health Care Innovation Project, the Blueprint for Health and the Green Mountain Care Board. DVHA supports improvements to emerging alternative payment models rather than reverting to a fee for service (FFS) approach to reimbursement for care management.

**Comment #2 (Physician):**

It appears that all specialties and non-physician providers will see a total increase; however, primary care will see a significant total decrease. Primary care physicians in this state are the backbone of your system and deserve better treatment. The state pays full rate for food programs, heating oil, etc.

However, if I care for an ill child or a patient with severe heart disease, the states response is to pay the least amount possible, even if it's less than the cost of providing the service. Good luck getting new primary care physicians to replace the significant upcoming wave of retiring primary care physicians with your present policies.

**Response:** The updates to the professional services fee schedule are budget neutral overall. The decrease represented in the provider impact tables, as referenced in the text of the document, are



directly related to the expiration of a federal funded program, which was mandated under the Affordable Care Act (ACA). For two years (CY2013-2014), qualifying primary care providers received enhanced rates for select services over those paid to other health professionals made possible by 100% federal funds. This program provided approximately 8 million additional funds annually to an estimated 1500 providers or \$6,600 per primary care provider. In CY2015, primary care providers will revert to receiving the same Medicaid rate paid to other health professionals under our CY2015 finalized policies. Therefore, the decrease is related to the expiry of this program which provided enhanced reimbursement and not to targeted rate decreases. DVHA supports continued investment in primary care through its participation in alternative payment model demonstrations like the MAPCP and VMSSP. Note also that federally qualified health centers (FQHCs/RHCs) were ineligible for this program and therefore are not impacted by this change.

**Comment #3 (VMS and AAP-VT):**

A Kaiser Family Foundation report from late October found that 15 states were planning to extend the EPCP Medicaid payments in some form through the 2015 fiscal year. We believe Vermont should follow the example of these states by appropriating funds in order to help preserve the ability of primary care physicians treating large numbers of Medicaid beneficiaries to stay in practice. We recommend that the Administration's SFY2015 Budget Adjustment Act and its SFY2016 Budget include sufficient funding to eliminate the 20 percent 2015 cut to primary care physicians and fund Medicaid reimbursement to primary care physicians at the Medicare level.

**Response:** The budget considerations are outside the scope of this proposed policy; these policies aim to update the data and methods used to set relative values and conversion factors budget neutral to previous spending. DVHA does support continued investment in primary care through its participation in alternative payment model demonstrations like the MAPCP and VMSSP. Note also that federally qualified health centers (FQHCs/RHCs) were ineligible for this program and therefore are not impacted by this change.

**Comment #4 (VMS and AAP-VT):**

DVHA's policy appears to be based solely on a desire to require Vermont's primary care physicians to participate in the state's Blueprint for health without allowing them an alternative option. Blueprint PMPM payments of \$2.00-\$2.50 have not increased since 2008, notwithstanding the increased administrative costs to meet the greater costs and administrative demands of NCQA accreditation. The DVHA policy preventing the ability of physicians to bill Medicaid for services related to CPT 99490 would deny primary care physicians the ability to select the option they feel best meets the needs of their eligible patients and assists the financial viability of their practices. We recommend that DVHA allow physicians to bill the new chronic care management (CCM) code (CPT 99490) and receive a prorated payment of \$40.39 per beneficiary per calendar month payment through the Medicaid fee-for-service professional fee

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schedule, unless the physician is receiving the average \$2.00-\$2.50 per Medicaid beneficiary per calendar month payments under the state's Blueprint for Health.

**Response:** The proposal is not to reimburse for these codes under FFS given Vermont Medicaid's participation in the MAPCP and existing support for the care management services described by the new service codes under this program. We are finalizing our decision not to make a beneficiary level distinction so not to dis-incent participation in the MAPCP and increase operational costs and administrative burden of Medicaid operations. Also, the PMPM payments are not directly comparable because there rules for attribution of patient are more generous under the MAPCP than would be allowed under the rules of

the fee for service code; said another way, the MAPCP makes more PMPM payments than would be eligible under the FFS code descriptor and federal regulations.

**Comment #5 (VMS and AAP-VT):**

While we are neutral on DHVA's voluntary reporting requirements for CPT 99490, we strongly oppose DHVA's proposed mandatory reporting of the new chronic care management code. The proposal would add a significant administrative burden on practices already overwhelmed with state-mandated ACO reporting requirements. This mandatory reporting is especially objectionable since DHVA is refusing to pay for the services under the new CCM code. We recommend that DHVA not require mandatory reporting of the new chronic care management code (CPT 99490).

**Response:** DVHA appreciates the administrative requirements associated with reporting and tries to limit administrative burden where possible. DVHA is finalizing the policy of voluntary reporting on the new chronic care management code (CPT 99490) for one year. DVHA will revisit mandatory reporting as part of its CY2016 annual update policies. Even though voluntary, DVHA strongly encourages providers to report the code so to help inform future decision making and evaluation of the value and quality of care management services provided by primary care providers in the State.

**Comment #6 (Consumer):**

How will changing the reimbursement rates influence the way in which doctors choose to prescribe/treat their patients? And, how will these changes affect the kind of care that patients get?



**Response:** The changes finalized for CY2015 aim to improve the effectiveness of the systems used to reimburse outpatient hospitals and health professionals. These changes contribute to care delivery improvements in the way doctors choose to prescribe or treat patients by ensuring the system of payment promotes efficiency and high quality. The annual update process uses more recent data and system updates to improve the integrity of the payment system. These changes are largely based on similar updates being used by the federally-run Medicare program. These changes were made based on the assumption of overall budget neutrality, after adjusting for the end of the federal enhanced funding primary care.