July 17, 2017

The Honorable Thomas E. Price, MD
Secretary, U.S. Department of Health & Human Services

The Honorable Seema Verma, MPH
Administrator, U.S. Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Price and Administrator Verma,

The Tennessee Medical Association (TMA), on behalf of its almost 9,000 physician members, requests your intervention in a recoupment battle we have been fighting with your predecessors and with our Medicaid program since August 2015. The recoupment relates to enhanced Medicaid payments paid to primary care providers (PCPs) in 2013 and 2014 as part of the Affordable Care Act. Due to unfair regulations promulgated by CMS in 2012, our Medicaid program known as TennCare will recoup almost $7 million from PCPs in Tennessee. With your appointments at HHS and CMS and President Trump’s “Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal” issued on January 20, 2017, we ask that you do what the previous administration would not: waive the Medicaid audit requirements in 42 CFR § 477.400 and stop the recoupments.

For the years 2013 and 2014, Congress mandated that physicians providing certain primary care services in the Medicaid program be reimbursed at 100 percent of the Medicare rate for certain Evaluation & Management (E&M) codes and vaccine administration codes. This was a significant increase in reimbursement since Medicaid reimburses physicians, on average, at around 66 percent of Medicare. The regulations promulgated by CMS to implement this enhanced payment required health care providers to either be board certified in a primary care specialty or qualify under a 60 percent threshold calculation. The 60 percent threshold required non-board certified providers to attest that 60 percent of their total paid codes submitted to Medicaid for the given year were for those specific E&M and vaccine administration codes included in the regulations. This is a difficult threshold for many


primary care providers to reach because most conscientious PCPs administer multiple services for each patient during a given office visit, thereby reducing the percent value assigned to the E&M and vaccine codes. The regulations then mandated that Medicaid agencies audit these providers at the close of the program to make sure they did in fact reach the 60 percent threshold. Our TennCare Bureau did just that in 2015 and as a result, will recoup almost $7 million from legitimate PCPs who failed the audit because of CMS’ unfair formula for calculating the 60 percent threshold.

In August 2015 when TMA first learned of the audit, we sent a letter to Acting Administrator Andrew Slavitt, explaining in detail why the 60 percent threshold calculation included in the regulation was unfair to non-board certified primary care physicians (Attachment 1). CMS responded that it would not retroactively change the audit criteria. A few months later we sent a second letter outlining reasons why CMS’ interpretation of its regulations was arbitrary and even provided an alternative interpretation that would more fairly identify non-board certified PCPs (Attachment 2). Again, CMS’ response was unmoving. In March 2016, the entire Tennessee congressional delegation signed a letter to CMS urging it to re-evaluate its audit criteria (Attachment 3), to which CMS responded in the negative.³ As you can see, the previous CMS administration was unwilling to admit that its regulations may have been flawed or even consider altering its interpretation of them in favor of PCPs.

As a result, in October 2016 twenty-one of the primary care providers impacted by the recoupment filed a complaint in federal court against CMS, arguing that the regulation is arbitrary and capricious and discriminates against certain PCPs.³ The litigation is in the summary judgment phase and may not be concluded for some time. If the court does not decide in the providers’ favor, then TennCare will move forward with its recoupments. The only remedy available to the providers at that point will be to appeal the court’s decision. Many of these providers are rural, solo practitioners who are already taking a financial hit by hiring attorneys to represent them at the district court level. They may not be able to afford an appeal.

Therefore, the TMA asks that you relieve these providers of that additional financial burden and loss of income due to the recoupment by following President Trump’s directive in the January 20th executive order and retroactively waiving the audit requirements of 42 CFR § 477.400. Section 2 of the executive order states,

To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the

³ For more information on TMA’s advocacy efforts related to the PCP Medicaid enhanced payment audit, please visit www.tnmed.org/TMA/Issues/ACA_Medicaid_Primary_Care_Rate_Bump_Audit.

implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.

The federal regulation in question, which was promulgated by CMS in order to implement Section 1202 of the Health Care Education and Reconciliation Act of 2010 as an amendment to the Patient Protection and Affordable Care Act, is a regulatory burden and cost to healthcare providers not only in Tennessee but in states across the country, and it is precisely the type of burdensome regulations that the President’s executive order was intended to address. From speaking with other state medical societies, we have gleaned that other Medicaid agencies have either audited only a small number of providers or have not yet conducted the audits required by 42 CFR § 477.400. Instead they are waiting to see what happens in Tennessee through TMA’s advocacy efforts and with the federal class action litigation. By waiving the state audit requirement, you would put an end to this waiting game and prevent the same types of recoupments from occurring in other states that currently threaten Tennessee primary care providers.

TMA appreciates the measures the current administration has already taken to reduce some of the regulatory burdens placed on Tennessee physicians. We ask that you continue to do so by waiving the audit requirements of 42 CFR 477.400. Thank you for your time and attention to this matter. If you need additional information or have any questions, please contact TMA’s Assistant General Counsel, Katie Dageforde Hartig, at katie.dageforde@tnmed.org.

Sincerely,

Yarnell Beatty, JD
Senior Vice President of Advocacy

CC:
US Senator Lamar Alexander
US Senator Bob Corker
US Representative Phil Roe, MD
US Representative Jimmy Duncan, Jr.
US Representative Chuck Fleischmann
US Representative Scott Desjarlais, MD
US Representative Jim Cooper
US Representative Diane Black
US Representative Marsha Blackburn
US Representative David Kustoff
US Representative Steve Cohen
August 28, 2015

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Slavitt,

On behalf of the 8,000 physician members of the Tennessee Medical Association (TMA), we would like to express our deep concern about the recoupment of the increased Medicaid payments for 2013 and 2014 from primary care physicians. In Tennessee, the Bureau of TennCare has conducted an audit of all physicians who attested in 2013 that certain E&M and vaccine administration codes, as identified by CMS, constituted at least 60 percent of their total Medicaid codes paid. The manner in which the threshold was calculated is in direct contradiction to the original intent of the ACA provision that mandated the increased Medicaid payment. The recoupment of these payments will have a significant negative impact on legitimate primary care providers who may not be able to survive as a result. They were not prepared for the possibility of a recoupment in 2013 when the payments initially started due to lack of consistent information from both CMS and TennCare. The TMA urges CMS to delay this recoupment and require TennCare to conduct the audit in a more accurate and fair manner. As the federal regulatory body responsible for implementing this program, it is CMS’s obligation to ensure it has the effect intended by the legislation.

Intent of ACA Section 1202

In general, the intent of section 1202 of the ACA was to directly benefit those providers who provide primary care services to Medicaid patients and to incentivize them to continue treating those patients.1 It is a well-documented fact that the United States has a shortage of primary care providers.2 Couple that with the fact that Medicaid, on average, reimburses providers at only 66 percent of Medicare rates3, and the necessity for this provision of the ACA is without question. For 2013 and 2014, primary care providers enjoyed, for a change, adequate reimbursement for office visits and routine services they

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1 “Qs & As on the Increased Medicaid Payment for Primary Care: CMS 2370-F (Set VI)” April 14, 2014.  
2 IHC Inc., The Complexities of Physician Supply and Demand: Projection from 2013 to 2025. Prepared for the  
   Association of American Medical Colleges. Washington, DC; March 2015.  
provided to Medicaid patients on a daily basis. With those increased payments, they were able to budget for new staff members and offer additional services to the poor and medically needy in their areas. Unfortunately, in many states like Tennessee, those increased payments were cut off on January 1, 2015. While that was a financial blow in and of itself, it was one for which these primary care providers could prepare. Now, mere months later, many of them are realizing they may be in for an even bigger financial hit—one they did not see coming.

The good intention of section 1202 of the ACA is now hurting the very providers it was meant to help through CMS’s interpretation and state Medicaid agencies’ implementation. That section states that State Medicaid agencies must include “payment for primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under” Medicare Part B. [Emphasis added] This language does not mention required board certification or a minimum claims threshold in order for primary care providers to qualify for the enhanced payments. Instead, that was part of CMS’s interpretation of the law.

While board certification is common practice now and a requirement for employment at many health care entities, that was not the case just two or three decades ago. Many older family practice physicians, especially those in rural areas, are not board certified by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS), or any other board for that matter. Doing so was simply not a necessity when they started practicing. Rural physicians, especially, did not have time to take off work and stop seeing patients in order to become board certified. Many of them were one of only a few primary care physicians in their area. Even today, it is not a requirement for family practice physicians who provide primary care services to Medicaid patients. However, in order to qualify for the 2013 and 2014 increased Medicaid payments, these physicians had to attest that 60 percent of their total paid Medicaid codes were for certain E&M codes and vaccine administration codes, according to CMS regulations. As we will explain, this method is not the best way to identify primary care providers.

Consequences of Calculating 60 Percent Threshold
Unfortunately, the method for calculating the 60 percent threshold inaccurately and unfairly determines who is considered a primary care physician. Because it includes all Medicaid billed codes in the numerator, it severely diminishes full-service family practices’ ability to reach the 60 percent based on E&M and vaccine codes alone. For example, if a patient comes into a physician’s office with a sore throat, the claim for that visit may include codes for the E&M visit, a strep screen, a CBC test, and an antibiotic injection—all typical primary care services. However, the E&M code would account for only 25

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4 42 USC 1396a(a)(13)(C)
5 42 CFR §477.400(a)
percent of that claim. If the majority of a physician’s office visits include similar services, as almost all efficient primary care visits do, then it is essentially impossible for him/her to reach the 60 percent threshold required to keep the increased Medicaid payment. It also indicates that using this calculation is not reflective of what constitutes primary care.

In Tennessee, our Medicaid managed care organizations (MCOs) started sending letters to physicians in early August notifying them of the audit and subsequent recoupment. One of the MCOs incorrectly sent these letters to a few hundred physicians who were actually board certified, and therefore automatically qualified for the increased Medicaid payment regardless of their number of E&M and vaccine codes. However, the reason they erroneously received the letters in the first place was because they had accidentally been included in TennCare’s audit and failed to reach the 60 percent threshold. This means that even board certified family and primary care physicians could not meet the 60 percent threshold requirement imposed on non-board certified physicians—just another illustration of why the calculation is not an accurate means of identifying Medicaid primary care providers.

The only way most family practitioners would be able to reach the 60 percent threshold is if they practiced “triage” medicine. Instead of cost effectively offering multiple services, such as labs and drugs, in one visit, practices would have needed to refer all of those services out to other facilities and bill for them independently. This would complicate treatment and disrupt continuity of care because of the inconvenience to the patients and increased likelihood that they would not comply. Alternatively, practices could have billed for ancillary services differently. For example, they could have billed for lab and x-ray codes using their clinic's NPI and billed the office visit code only under the physician's NPI. This would involve filing several claims for the same date of service for each patient, which would have been redundant and potentially resulted in audits from the TennCare MCOs. Large clinics and solo practitioners practicing in a larger city have the advantage of outsourcing labs, x-rays, etc., and therefore may qualify without much consequence. But rural physicians in medically underserved areas may not have that option.

As a result, this audit and recoupment is hurting the physicians who needed the increased payments the most. All of the physicians we have heard from are solo or small group practices in rural, medically underserved areas of Tennessee. One physician we spoke to in Shelbyville, Tennessee, will have almost $300,000 recouped due to this audit. Shelbyville is a low income area, and his practice is 40 percent Medicaid patients. Another practice that received a recoupment letter contacted us from Brownsville—another high Medicaid population—and knew of at least three other family physicians in their town who also failed the audit. This practice may have to stop treating Medicaid patients due to the financial hardship imposed by the roughly $250,000 they will have recouped. This program, designed to incentivize primary care physicians to treat more Medicaid patients, may end up causing the opposite effect because of its poor implementation.
Discrepancy between CMS PCP Payment Programs

The TMA understands that CMS’s job as a federal regulatory body is to interpret broad statutory requirements so that they are implementable by the individuals required to abide by them. In the case of section 1202 of the ACA, it seems that CMS looked to the regulatory requirements already in place for another primary care program—the Medicare Primary Care Incentive Payment (PCIP). As you know, the PCIP program began in 2011 and goes through the end of 2015. It offers quarterly incentive payments to Medicare primary care physicians who qualify. Similar to the Medicaid enhanced payments, primary care physicians qualify for the PCIP if certain E&M codes constitute at least 60 percent of their total allowed charges under the Medicare physician fee schedule for a given year. However, unlike the Medicaid program, “emergency, hospital inpatient, drug and laboratory charges are excluded when calculating the practitioner’s total allowed charges.” Doing so makes it more likely for primary care physicians to meet the 60 percent threshold, since ancillary services like drugs and labs provided during an office visit do not dilute the amount of E&M codes.

Instead, for the Medicaid enhanced payment program, the 60 percent threshold was based on a provider’s entire amount of Medicaid codes submitted. At least 60 percent of the provider’s total Medicaid codes paid had to be E&M (99201 through 99499) and vaccine administration codes (90460, 90461, 90471, 90472, 90473, 90474, or their successors). The total Medicaid codes paid include labs, x-rays, and any other non E&M and vaccine codes paid. As previously mentioned, most family practices provide these services in-house during a normal office visit, as opposed to referring them out to more expensive facilities. Including them in the numerator severely hampers their ability to meet the threshold.

Utilizing a different calculation for the Medicaid payment led to confusion amongst primary care providers. To determine eligibility for the PCIP payments, Medicare physicians in Tennessee can enter their NPI number into a portal on Cahaba GBA’s website, our region’s Medicare Administrative Contractor (MAC). Many primary care physicians we spoke to assumed, erroneously, that if they qualified for the PCIP through that portal, then they would qualify for the Medicaid increased payment as well, since they were both federally-mandated incentive payments. While incorrect, the assumption was a logical one. Why would CMS choose to calculate the 60 percent threshold differently for similar

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6 Primary Care Incentive Payment Program (PCIP); Medicare PCIP Payments for 2012 are over $664* million, CMS; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2012-Payments.pdf
7 While this is the range of codes stipulated by CMS, TennCare and its MCOs did not include all of these codes in its enhanced payment calculations as they were not reimbursable under the 2009 fee schedule used for this program. “Increased Primary Care Services Payment 42 CFR 447.405, 447.410, 447.415,” TennCare State Plan under Title XIX of the Social Security Act: Methods and Standard for Establishing Payment Rates – Other Types of Care, Attachment 4.19-B, p. 100-103; January 1, 2013. http://tn.gov/assets/entities/tenncare/attachments/4-19-b.pdf
8 Primary Care Incentive Payment (PCIP) Lookup, Cahaba GBA. https://www.calabagba.com/part-b/claims-2/primary-care-incentive-payment-pcip-lookup/
primary care incentive payments? The only logical conclusion is that it wanted fewer providers to qualify for the Medicaid program.

**Ambiguity in Information Provided by CMS and TennCare**

Back in 2013 when physicians were required to attest, the criteria for calculating the 60 percent threshold was anything but clear to them. The attestation form that the TennCare MCOs sent to physicians in mid-2013 stated that “at least 60 percent of [the physician’s] total Medicaid codes paid for the most recently completed calendar year” had to be E&M and vaccine administrative codes. Most physicians interpreted that statement to mean the total dollar amount associated with the payments for those codes had to equal 60 percent of their total payments from TennCare. Under that logic, many of them would have easily surpassed the 60 percent threshold.

Additionally, while some information distributed by CMS and TennCare referred specifically to “codes,” an equal amount mentioned “claims” as the vehicle for calculating the 60 percent threshold. These two terms were used interchangeably. Many physicians interpreted this to mean the calculation would rely on the number of claims they submitted that included those specific E&M and vaccine admin codes, instead of counting each individual code. For example, a practice may submit one claim with four different codes: E&M visit, lab test, CBC test, and antibiotic injection. Many physicians assumed that because the claim included an E&M code, it would count as one claim in TennCare’s calculation of the 60 percent threshold. Because almost all claims for primary care practice visits include an E&M code, physicians assumed they would easily reach the threshold and qualify for the payment.

Finally, the federal regulations promulgated by CMS required state Medicaid agencies to annually “review a statistically valid sample of physicians who received higher payments to verify that they meet the requirements of” the program. According to TennCare, it did not conduct these audits annually, but instead waited until the program ended. It also chose to audit the entire population of physicians who attested rather than auditing only a statistically valid sample as the regulation required. If they had conducted the audits annually, some of these physicians would have been notified that they did not meet the 60 percent threshold then and would have stopped receiving the enhanced payments. Instead, they did not find out until over two years later after they had already absorbed these funds into their business operations.

TennCare audited roughly 900 physicians who attested and found that around 300 of them failed to meet the 60 percent threshold. That is approximately one-third of all the physicians who attested to

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9 TennCare PCP Attestation Form. https://www.tn.gov/assets/entities/tenncare/attachments/TN1202Self-AttestationForm.pdf

10 42 CFR 400.477(b).

11 Technically, only around 650 of the 900 should have been included in the audit. As previously mentioned, a couple hundred board certified physicians were erroneously included in the audit.
being primary care providers. According to TennCare’s data, these physicians are not ancillary specialists who should never have attested in the first place. They are family medicine practitioners, pediatricians, general practitioners, and internal medicine specialists—the types of designated specialties specifically listed in section 1202 of the ACA. Their status as primary care providers is without question, and yet they will be losing substantial amounts of money they earned caring for Medicaid patients based on an unfair calculation of codes.

For the past several weeks, TennCare has informed the TMA that this audit and its criteria were a requirement mandated by CMS to every Medicaid agency in the country. So far, neither the American Medical Association nor any other state medical associations with whom we have communicated are aware of similar audits happening in other states. If other states had similar outcomes, CMS would have been made aware of it by now. Either Tennessee is ahead of the game, or TennCare’s audit used harsher calculations than any other state Medicaid agency. Either way, the TMA strongly urges CMS to implement a fairer process, such as mirroring the Medicare PCIP program, for calculating the 60 percent threshold for physicians who received the increased Medicaid primary care payments in 2013 and 2014.

Thank you for your time and consideration of this matter.

Sincerely,

[Signature]

Katie Dageforde, JD
Assistant General Counsel

CC:
Vaughn Frigon, MD, Chief Medical Officer, Bureau of TennCare
US Senator Lamar Alexander
US Senator Bob Corker
US Representative Phil Roe, MD
US Representative Jimmy Duncan, Jr.
US Representative Chuck Fleischmann
US Representative Scott Desjardais, MD
US Representative Jim Cooper
US Representative Diane Black
US Representative Marsha Blackburn
US Representative Stephen Fincher
US Representative Steve Cohen
Annalia Michelman, JD, American Medical Association
December 21, 2015

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children’s Health Operations
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

Dear Ms. Glaze:

Thank you for your letter, dated September 28, 2015, responding to the concerns of the Tennessee Medical Association (“TMA”) outlined in my letter to Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services (“CMS”). We appreciate your taking the time to provide insight into development of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education Reconciliation Act of 2010 (“Section 1202”).

While TMA understands CMS’ concerns regarding “retroactively chang[ing] the qualifying criteria” for the enhanced payments under Section 1202, a retroactive change is unnecessary to mitigate the regrettable impact of Tennessee’s interpretation of CMS’ regulation on the very providers Congress intended Section 1202 to benefit. Although your letter stated that “Tennessee correctly implemented the regulations,” Tennessee’s application does not effectuate the intent of CMS in adopting the regulation, and it is neither the only nor most reasonable understanding of the regulatory language.

We urge CMS to clarify to the state of Tennessee that other interpretations of the regulation are equally—if not more—appropriate. In particular, CMS should permit states, when applying the 60 percent threshold test mandated by the regulation, to review only claims for physician services.

1. Based on Tennessee’s application, the CMS regulation is not a reasonable construction of Section 1202.

Section 1202 required state Medicaid programs to pay for primary care services furnished in 2013 and 2014 “by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent” of the Medicare rate. 42 U.S.C. § 1396a(a)(13)(C). CMS purported to effectuate Congressional intent by defining eligible primary care physicians as those physicians either board-certified in applicable specialties or subspecialties, or a physician for whom most (60%) of the Medicaid services furnished in the prior calendar year were defined by Congress or CMS as “primary care services.” 77 Fed. Reg. at 66,700-01. The latter test (referred to by CMS and herein as the “60 Percent Threshold”) provides that an eligible physician must attest to the state that he or she:
Has furnished evaluation and management services and vaccine administration services under codes described in paragraph (b)\(^1\) of this section that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed CY or, for newly eligible physicians, the prior month.

42 C.F.R. § 447.400(a). The state then must “review a statistically valid sample of physicians who received higher payments to verify that they meet the requirements.” Id. § 447.400(b).

As discussed in our earlier correspondence, Tennessee interpreted the CMS regulation to require review of the number of primary care services furnished by a physician not as a percentage of the total services furnished by that physician, but as a percentage of all services billed under the physician’s provider number, regardless of whether those services were furnished or supervised by the physician. As explained below, Tennessee’s test lacks a logical connection to what it purports to measure (i.e., whether a physician qualifies as a “primary care physician”). Moreover, Tennessee’s approach is arbitrary and capricious in that it discriminates among physicians providing identical services to similarly-situated patients based exclusively on differences in administrative billing practices.

For these reasons, if CMS were to adopt Tennessee’s approach as the exclusive interpretation of its regulation, no court would uphold the regulation as a reasonable interpretation of Congress’ intent to enhance payments to primary care physicians. See Chevron USA Inc. v. Natural Resources Defense Council, Inc., 467 US 837, 843-44 (1984) (holding that courts defer to agency regulations only when the regulation is a reasonable interpretation of Congressional intent).

a. Ancillary services are irrelevant for purposes of identifying primary care physicians.

Basic diagnostic testing (e.g., urinalysis, EKGs, pregnancy tests, strep screenings), simple imaging (e.g., x-rays and ultrasounds), and other ancillary services (e.g., antibiotic injections) are an integral part of most primary care practices. In fact, most health insurers, including TennCare managed care organizations, encourage primary care providers to provide these services for purposes of increasing their HEDIS scores.\(^2\) Usually, technicians or nurses provide these ancillary services under the general supervision of a physician. Although typically not directly furnished or supervised by the ordering physician, the physician (or, where applicable, the group practice) bills for ancillary services furnished by personnel in the same office.

A physician’s ability to offer on-site ancillary services has no bearing on whether the physician devotes the majority of his or her time to providing primary care services. For this reason, including ancillary services in the calculation of total services furnished by a physician for purposes of the 60 Percent Threshold leads to unintended results. Instead of measuring whether a physician predominantly furnishes primary care, the resulting percentage primarily reflects the availability of ancillary services in the physician’s office. Thus, by calculating the number of primary care services furnished by a physician as a percentage of all services billed under the physician’s provider number, regardless of whether those services were furnished or supervised by the physician, Tennessee’s application of the 60 Percent

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\(^1\) This reference in the regulation should presumably be to paragraph (c).

\(^2\) The Healthcare Effectiveness Data and Information Set (HEDIS) measures designed by the National Committee on Quality Assurance (NCQA) are utilized by health plans to measure health care performance. Many of the HEDIS quality measures include preventive services, such as screening for certain types of viruses. These preventive measures require primary care providers to perform ancillary services, such as lab tests, on a regular basis.
Threshold yields a number with no logical bearing on whether a physician predominantly practices primary care.

To further illustrate the inherent logical flaw in Tennessee’s application of the 60 Percent Threshold, consider an example of a typical percentage measurement adopted by CMS in another context—in this case, a quality measure for Accountable Care Organizations ("ACOs") that quantifies "the percent of primary care physicians [PCPs] who successfully qualify for an EHR Program Incentive Payment."\(^3\) Expressed in mathematical terms, that test looks like this:

\[
\% = \frac{\text{All PCPs participating in an ACO in the reporting year who qualify for an EHR incentive payment}}{\text{All PCPs participating in an ACO in the reporting year}}
\]

The only difference between the numerator and denominator in the formula above is the characteristic being measured—whether the PCP qualified for an EHR incentive payment. This structure is essential to any meaningful percentage measurement. For example, to determine how many cars in Baltimore are red, the numerator would be “red cars in Baltimore” and the denominator would be “cars in Baltimore”:

\[
\% = \frac{\text{Red Cars in Baltimore}}{\text{Cars in Baltimore}}
\]

The following formulas would not provide a valid percentage of red cars in Baltimore, despite the fact that the numerator is comprised of “red cars in Baltimore”:

\[
\% = \frac{\text{Red Cars in Baltimore}}{\text{Cars and Motorcyles in Baltimore}}
\]

\[
\% = \frac{\text{Red Cars in Baltimore}}{\text{Cars in Baltimore+Motorcyles in Washington, D.C.}}
\]

Although this may seem like a frivolous analogy, it demonstrates why no court would find Tennessee’s application of the CMS regulation to be a “reasonable” effectuation of Congress’s intent. In fact, Tennessee’s application of the 60 Percent Threshold looks remarkably similar to the final example above:

\[
\% = \frac{\text{Primary Care Services Furnished by Physician}}{\text{All Services Furnished by Physician+Ancillary Services Furnished in the Same Group Practice}}
\]

This formula produces a meaningless percentage due to the mismatch between the numerator and denominator. The numerator includes only physician services, while the denominator includes non-physician ancillary services that are irrelevant to determining the portion of a physician’s practice devoted to primary care. If it adopts Tennessee’s application as the only correct interpretation of the 60 Percent Threshold, CMS will be unable to defend the regulation as a rational choice for defining a primary care physician. See, e.g., Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co., 463 U.S. 29, 43 (1983) (agency must articulate satisfactory explanation for its action, including “a

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\(^3\) This is one of many similar percentage measurements that CMS has developed. The specifics of this particular measure were obtained from the CMS Measure Information Form, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-11.pdf.
rational connection between the facts found and the choice made\textsuperscript{"} (internal quotation marks and citation omitted).

\textbf{b. Tennessee's approach arbitrarily distinguishes between identically positioned physicians.}

Further demonstrating the arbitrary nature of Tennessee's approach, physicians practicing as part of a group practice may avoid the impact of including ancillary services in the 60 Percent Threshold calculation by simply choosing an alternative—but equally permissible—method for billing those services. In Tennessee, as in many state Medicaid programs, physicians and group practices generally have discretion to bill ancillary services performed in their office under the billing number of (1) the supervising physician; (2) the ordering physician; or (3) the billing number of the group practice of the ordering and/or supervising physician. See, e.g., CMS Manual 100-04, Ch. 16, 50.2 & Ch. 13, § 20 (guidance applicable to Medicare but followed by many state Medicaid programs). Physicians and physician groups choose how to bill ancillary services based on various historical, logistical, and administrative factors.\textsuperscript{4}

Thus, for a physician practicing as part of a group practice, the services billed under that physician’s provider number might include no ancillary services at all—if such services were billed under another provider number—or could include some or all of the ancillary services performed by technicians in the same office if that physician either ordered the services or provided general supervision of the technicians. Since these options are only available for physicians practicing as a group, a solo practitioner must supervise and bill any ancillary services provided in his or her office. Accordingly, qualifying under Tennessee's 60 Percent Threshold calculation arbitrarily hinges on whether a particular physician is part of a group practice and, if so, how that group practice bills for ancillary services—rather than on any legitimate consideration of whether a physician qualifies as a primary care physician.

In fact, in interpreting a similar Congressional test for identifying primary care practitioners (discussed more fully below), CMS explicitly recognized concerns that billings under a practitioner’s provider number “would depend upon the organizational structure of the potential primary care practitioner’s practice and, therefore, would be unrelated to whether the provider was serving as a ‘true primary care practitioner,’” stating:

\begin{quote}
We also believe that it is important that the eligibility determination be based on a fair representation of potential primary practitioners’ services so that “true primary care practitioners” may meet or exceed the qualifying primary care percentage threshold for the [incentive payment], regardless of how they may have chosen to organize their medical practice.
\end{quote}

See CMS, Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, 75 Fed. Reg. 73,170, 73,434 (Nov. 29, 2010). CMS should permit states to interpret its regulation in a way that ensures eligibility for the enhanced payments is “based on a fair representation” of the physicians’ services.

\textsuperscript{4} If physician groups had known at the time of billing that Tennessee would include ancillary services in calculating the 60 Percent Threshold, some may have chosen a different method for billing ancillary services.
2. The 60 Percent Threshold permits the same flexibility as the parallel statutory formula\(^5\) in Section 5501(a) of PPACA.

As noted in your September 28 letter, CMS “borrowed” the 60 Percent Threshold from section 5501(a) of the Patient Protection and Affordable Care Act (“PPACA”). See CMS, Payments for Services Furnished by Certain Primary Care Physicians, 77 Fed. Reg. 27,691, 27,675 (May 11, 2012). In that section, Congress included a similar 60 percent test to determine which practitioners qualified as primary care practitioners for enhanced payments under Medicare. See PPACA, Pub. L. No. 111-148, § 5501(a) (2010), codified at 42 U.S.C. § 1935(k)(x) (defining primary care practitioner as a practitioner “for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period”).

CMS initially proposed that a practitioner’s total allowed charges under Part B comprise the denominator for the statutory test. See CMS, Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, 75 Fed. Reg. 40,040, 40,137 (Jul. 13, 2010). After commenters argued that including charges for ancillary services in the denominator would prevent “true primary care practitioners” from qualifying under the statutory test, CMS acknowledged that Section 5501 of PPACA allowed “some flexibility in implementing the . . . primary care percentage calculation.” Accordingly, CMS revised the formula to remove all charges not reimbursed under the Medicare Physician Fee Schedule, as well as other charges that CMS believed might contribute “to bias against ‘true primary care practitioners’ who provide a full spectrum of care to their patients.” See 75 Fed. Reg. at 73,434.

CMS thus concluded that the revised calculation, which excluded certain non-physician and other services from the denominator, appropriately effectuated the statutory mandate that primary care services account for at least 60 percent of “the allowed charges under this part for such physician or practitioner.” See PPACA § 5501(a). Similarly, CMS should clarify that states should interpret the parallel regulatory test under Section 1202, which references “the Medicaid codes [the physician] has billed,” to eliminate codes in the denominator that could “lead to bias against true primary care practitioners.” 75 Fed. Reg. at 73,434 (internal quotation marks omitted).

3. When applying the 60 Percent Threshold, state auditors should limit the sampled claims to physician services.

In its final rule and in response to questions on its website, CMS provided substantial guidance to states to assist in determining which services fall within the numerator of the 60 Percent Threshold. However, CMS did not explicitly address how to determine which services fall within the denominator.\(^6\) Given the lack of guidance on the issue, Tennessee’s application of the regulation may represent a valid reading of

\(^5\) Other than the use of “billed codes” in place of “allowed charges,” the statutory test at section 5501(a) of PPACA and the CMS regulation for Section 1202 are substantively identical. Although the use of billed codes in place of allowed charges exacerbates the issues caused by inclusion of ancillary services, if states limit the denominator to codes reimbursed under the Medicare Physician Fee Schedule (as CMS did for section 5501(a) of PPACA), this alone should reduce the number of “true primary care practitioners” that fail to qualify for the enhanced payments.

\(^6\) In its Qs and As on the Increased Medicaid Payment for Primary Care, CMS 2370-F (Set III), CMS noted that “the numerator equals total billed codes for E&M services for the primary specialty, plus vaccine administration services, and the denominator equals the total number of billed codes.” This is the only statement from CMS with regard to defining the denominator, and it offers no guidance that goes beyond the regulatory text.
the plain text of the regulation, but it results in an irrational test that clearly conflicts with Congressional intent.

The best way to harmonize the existing regulation with CMS guidance and Congressional intent is to measure the 60 Percent Threshold by reference only to physician services covered as part of Medicaid’s physician services benefit, as defined in section 1905(a)(5) of the Social security Act. To appropriately measure the percentage of a physician’s practice devoted to providing primary care services, the only difference between services quantified in the numerator and denominator should be whether the services are primary care services. Accordingly, states should consistently apply CMS guidance for defining the services included in the numerator of the 60 Percent Threshold test to the denominator as well. Specifically, to be included in either the numerator or the denominator of the test, “services must be delivered under the Medicaid physician services benefit.” See CMS, Qs and As on the Increased Medicaid Payment for Primary Care, CMS 2370-F (Set I).

TMA urges CMS to clarify to Tennessee that its application of the 60 Percent Threshold is not the only correct interpretation of the regulatory text. We also request that CMS explicitly authorize Tennessee and other states to limit the sampled claims to physician services when auditing compliance with the 60 Percent Threshold. This approach is more legally sound and will better serve the public policies underlying the regulation.

Sincerely,

Katie Dageforde, J.D.

cc:
Linda Tavener, CMS Central Office
Janet Freeze, CMS Central Office
Darin Gordon, Director, Bureau of TennCare
Vaughn Frigon, MD, Chief Medical Office, Bureau of TennCare
US Senator Lamar Alexander
US Senator Bob Corker
US Representative Diane Black
US Representative Marsha Blackburn
US Representative Steve Cohen
US Representative Jim Cooper
US Representative Scott Desjarlais, MD
US Representative Jimmy Duncan, Jr.
US Representative Stephen Fincher
US Representative Chuck Fleischmann
US Representative Phil Roe, MD

7 CMS also stated that the increased payment is only available for services of non-physician practitioners if provided under the personal supervision of a physician. See CMS, Qs and As on the Increased Medicaid Payment for Primary Care, CMS 2370-F (Set II). We would suggest that this limitation be applicable to services included in the denominator as well.
March 3, 2016

The Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave, S.W.
Washington, D.C., 20201

Dear Mr. Slavitt:

We write regarding our concerns with the Increased Medicaid Payments for Primary Care Physicians program created in Section 1202 of the Health Care and Education Reconciliation Act of 2010. As we continue to hear from physicians in Tennessee, we fear the intent of the program to encourage more providers to accept Medicaid patients will not be realized, and the program as currently implemented will have the opposite effect of its goals and will instead limit access and discourage physicians from participating in the Medicaid program, especially now that the President has proposed extending the program through 2017 in his budget. We ask that the Centers for Medicare and Medicaid Services (CMS) evaluate its interpretation of the 60 percent threshold used to determine eligibility for the increased payments and delay recoupments until all states have finished auditing to ensure the program does not have these unintended consequences.

The Increased Medicaid Payments for Primary Care Physicians program required participating state Medicaid programs to pay for primary care services provided in 2013 and 2014 at the same level as Medicare rates. To determine program participation, CMS required physicians either be board-certified or report that 60 percent of Medicaid services provided were for evaluation and management services or vaccine administration, including ancillary services as part of total services billed. Due to confusion related to this 60 percent threshold, about 140 physicians in Tennessee are facing recoupments totaling more than $7.5 million.

Additionally, we believe other states may not have completed their audits of the enhanced payments and may experience similar findings of physicians being out of compliance with the threshold. We ask that CMS not recoup any incentive payments for participation in the program until all other states have completed their audits. This will allow for a complete assessment of the program and its holistic impacts on providers and Medicaid beneficiaries.

CMS has indicated that it is not considering alternate interpretations of the regulation and guidance related to the program in correspondence with the Tennessee Medical Association. We are concerned about the formula used for validating participation in the program and ask that you examine the regulation and guidance, considering the potential for discouraging physicians from caring for Medicaid beneficiaries.

As both Medicare and Medicaid take steps toward rewarding quality and incentivizing certain types of care, it is critical that we monitor and evaluate these changes to ensure their intended outcomes are realized and that beneficiaries are not compromised as a result of new programs or policies. We ask that you review participation requirements for the Increased Medicaid Payments for Primary Physicians and delay recoupments until all states have finished auditing to ensure the program does not have the
unintended consequences of discouraging provider participation in Medicaid and limiting access to beneficiaries.

Sincerely,

Lamar Alexander
United States Senator

Bob Corker
United States Senator

Diane Black
Member of Congress

Marsha Blackburn
Member of Congress

Steve Cohen
Member of Congress

Jim Cooper
Member of Congress

Scott DesJarlais
Member of Congress

John J. Duncan
Member of Congress

Stephen Fincher
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Chuck Fleischmann
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Phil Roe
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