November 14, 2014

Alexander Melis, Project Manager
Texas Health and Human Services Commission
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Sent via email

Dear Mr. Melis:

On behalf of the undersigned organizations, representing the state's physicians, nurses, and physician assistants, we are writing regarding proposed amendments to §354.1001, concerning Claim Information Requirements, and §354.1062, concerning Authorized Physician Services, as published in the October 17, 2014 *Texas Register*.

We strongly oppose this proposed change in payment. Currently, if an advanced practice registered nurse (APRN) or physician assistant (PA) bills a service under a supervising physician's Medicaid number, Medicaid pays the APRN or PA at 100 percent of the physician fee schedule. However, HHSC is proposing to amend reimbursement rules to specify that the payment rate for the supervised services should be paid at 92 percent of the physician fee schedule, the rate currently paid when an APRN or PA bills services under their own number. An eight percent payment cut for APRNs and PAs practicing in a team-based practice will undermine Medicaid's efforts to recruit and retain not only these providers, but also physicians seeking to practice in team settings.

Given the legislative directive to implement the change, we understand HHSC may be unable to evade implementation of the proposed changes. However, we ask that any such proposal consider the practical impact on team-based practices that voluntarily participate in the Medicaid program and the patients they serve. In August, our organizations submitted a letter to HHSC recommending that the state continue to pay 100 percent of the physician fee schedule when the supervising physician for an APRN or physician assistant "directly engaged in the provision of a service," with "directly engaged in provision of a service" defined to mean the engagement of a physician's independent medical judgment in relation to a specific patient encounter.

In the proposed rules, HHSC suggests similar language. It states that services provided by an APRN or PA will be paid at 100 percent of the physician fee schedule when the supervising physician "made a decision regarding the patient's care or treatment during the billable medical visit." Our organizations' proposed language and HHSC's is substantially similar, except for one key issue: HHSC specifies that 100 percent will be paid only if the supervising physician made a decision regarding the patient's care <u>during the billable medical visit</u> (emphasis added). We object to the underlined phrase.

By including the language "during the billable medical visit," it implies that if a physician and APRN or PA confer on a case after the patient has been seen, such as at a mid or end of day conference, the state will not pay 100 percent. It is absolutely impractical and unrealistic to expect that the supervising physician and APRN or PA will be able to discuss all cases immediately. At the time an APRN or PA is developing or revising a patient's plan of care, the supervising physician may be seeing other patients or performing a procedure, thus unable to discuss the case. The proposed language seems to preclude scenarios where the APRN/PA sees the patient, develops/revises a plan of care, then subsequently discusses it with the supervising physician. In such a scenario, the APRN or PA would follow up with the patient after consulting with the supervising physician. As we interpret the proposed rules, the APRN or PA would not be paid 100 percent of the physician fee schedule in this scenario because the consultation did not occur "during the billable medical visit."

Given these concerns, we strongly recommend striking the phrase "during the billable medical visit" so that team-based practices have more flexibility as to when the supervising physician and APRN/PA can confer. If there is concern that striking the phrase "during the billable medical visit" would make the timing of the physician's decision-making too nebulous, we alternatively propose establishing a reasonable timeframe, such as within 48 hours, in which the consultation between the supervising physician and APRN or PA must occur.

Similarly, in §355.8281, the proposed rule states that 100 percent of the physician fee schedule will be paid if the "physician made a decision about patient care while the service was being rendered" (emphasis added). The language in §354.1062(d)(1) refers to "during the billable medical visit." If the rule qualifies when the decision-making process occurs, the language should be consistent between §354.1062 and §355.8281.

In a related, but separate proposed rule change, HHSC proposes to amend §354.1001 to require a supervising physician to indicate on the claim when a services were performed by an APRN or PA, as appropriate. We support this proposal as it is consistent with improving transparency and accountability for who is actually providing the service.

As recommended in our September letter, we also request that when a physician claim is submitted for a service performed by an APRN or PA, the provider number of that individual APRN or PA be required to be provided on the claim. This request is similar to HHSC's proposed amendments to §§354.1001, 355.8093 and 355.8281 requiring a supervising physician to indicate on the claim when services were performed by an APRN/PA. Although the proposed language would improve the data collected on the *type of provider* actually providing the services, it will not provide accurate data about the *individual provider* who actually provides the service. For example, when a physician is delegating to two APRNs or PAs, the delegating physician indicating that the services were delegated to an APRN would not provide data about which APRN was providing the service. Requiring the individual provider number of the APRN/ PA on the claim is needed for accurate data about the individual APRN/PA performing the service.

Requiring the provider number of the individual APRN/PA performing the service has several benefits. Most importantly, it reduces the appearance of fraud. The OIG has developed an advanced graph pattern analysis technology (LYNXeon) to increase detection of Medicaid fraud. Unfortunately in detecting billing outliers it cannot differentiate between providers legitimately billing for those to whom they have delegated authority and those providers who are fraudulently overbilling. Requiring the APRN/PA provider number solves that and also improves the state's ability to track quality of care outcomes. There is no way to compare outcomes if the provider is not identified. As we move to a pay for performance system this increases in importance.

As you know, provider participation in Medicaid continues to drop. According to the preliminary results of the Texas Medical Association's 2014 physician survey, only 34 percent of physicians continue to accept all new Medicaid patients, compared to 67 percent in 2000. Our organizations' respective members, along with a diverse array of consumer groups, regularly report to lawmakers and HHSC that network adequacy is a pressing concern. Indeed, several HHSC advisory committees are currently exploring issues related to network adequacy in greater depth. In particular, we are worried about the impact the rule change will have on rural and border communities, where team-based practice has become an essential, cost-effective means to delivering primary and preventive care as well as specialty services.

The lynchpin of Texas' efforts to modernize the Medicaid delivery system is team-based practice, which is an essential element of almost all emerging delivery models – accountable care organizations, integrated delivery systems, and patient-centered medical homes. Studies in both the public and private

sector show that multidisciplinary, team-based practice improves quality and availability of services, while also lowering cost growth. Exacting an eight percent payment cut for clinicians at the forefront of redesigning Texas' Medicaid delivery model will stymie practice innovation and ultimately hinder Medicaid HMO efforts to partner with their network providers to implement new models of care.

Thank you for your consideration.

Sincerely,

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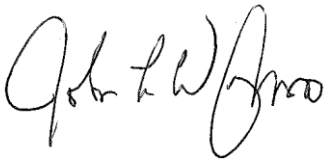

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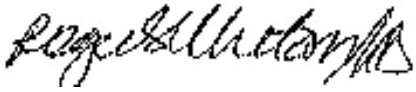

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