



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 22, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1590–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013

Dear Ms. Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the proposed Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 as published in the July 30, 2012 *Federal Register*.

In this proposal, the Centers for Medicare & Medicaid Services (CMS) estimates that the statutory formula used to determine Medicare physician payments in 2013 will result in a 27 percent decrease. The AAFP continues to call on Congress to stabilize Medicare physician payments by repealing the flawed sustainable growth rate formula and specifying a positive annual payment update for the next three to five years while demonstration programs undertaken by CMS and others generate data to determine the best alternative payment methods moving forward. To begin closing the gaping disparity between payments for primary care and subspecialist services, the AAFP strongly recommends that Congress stipulate a higher rate (of at least a 2% differential) for primary care services provided by primary care physicians.

In general, the proposed regulation confirms that CMS is committed to developing new methods to pay primary care services under the Medicare physician fee schedule. The AAFP lauds CMS for promoting the value of primary care. An investment in primary care is the most efficacious way to improve the quality of healthcare services provided to Medicare beneficiaries while simultaneously restraining rising healthcare costs. This commitment to primary care will begin to address the looming shortage of primary care physicians in America.

To improve the final 2013 Medicare physician fee schedule rule, in summary the AAFP:

- Supports CMS's proposal to create a post-discharge transitional care management as a short term payment strategy, however the AAFP urges CMS to restrict use of this code to the patient's primary care physician.

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- Supports CMS's intent to investigate potentially misvalued codes and to do so outside current processes.
- Urges CMS to not implement the Institute of Medicine's recommendations pertaining to geographic practice cost indices and instead refocus efforts on ensuring a properly distributed healthcare workforce that is meeting the demands of a growing beneficiary population.
- Supports the proposals to add recently covered "additional preventive services" to the list of Medicare telehealth services for 2013.
- Agrees with the proposal to add coverage of "additional preventive services" however the AAFP questions several of the proposed payment amounts.
- Considers the proposal to require that a physician has a face-to-face encounter with a beneficiary within 90 days before or 30 days after a written order for certain Medicare-covered durable medical equipment as reasonable.
- Appreciates that CMS proposes to establish a Physician Quality Reporting System (PQRS) informal review process and that the agency proposes to continue most of the program uninterrupted.
- Supports the CMS proposal to create new criteria for being a successful electronic prescriber for groups of 2-24 eligible professionals using the eRx GPRO. The AAFP also supports the proposal to establish an informal review process.
- Strongly supports CMS's proposal to streamline the implementation of the PQRS incentive and reporting programs within the context of the Medicare Shared Saving Program.
- Mostly supports CMS proposal to begin applying the value-based payment modifier only to groups of 25 or more eligible providers in 2015 so the agency can begin learning how to properly fulfill the statutory requirements. However the AAFP remains concerned with CMS's inability to specify the exact amount of the upward payment adjustment because of budget neutrality considerations.
- Fully supports the agency's proposal to begin Medicare Part B coverage of the Hepatitis B vaccine for high risk groups, specifically persons with diabetes.

Section II.H. Primary Care and Care Coordination

In the proposed regulation, CMS observes that, *In recent years, we have recognized primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth.* After listing many concurrent initiatives designed to encourage the long-term investment in primary care, CMS then asserts a commitment to continue to explore other potential short term refinements to the physician fee schedule that would appropriately value primary care and care coordination services within Medicare's payment system.

The AAFP greatly appreciates these statements and the fact that CMS continues to recognize the value of primary care services. Before commenting on CMS's proposal to create and provide payment for a post-discharge transitional care management code, the AAFP takes this opportunity to encourage CMS to explore thoroughly the short- and long-term payment strategies for improving primary care payments as suggested in the AAFP's March 12, 2012, [letter](#) to CMS that conveyed the recommendations of the AAFP's Task Force on Primary Care Valuation. We remain firmly committed to working with CMS to achieve these policy goals.

In the proposed regulation, the agency notes that they continue *...to hear concerns from the physician community that the care coordination included in many of the evaluation and management (E/M) services, such as office visits, does not adequately describe the non-face-to-face care management work involved in primary care.* Noting that *the current E/M, office, and outpatient visit CPT codes were designed to support all office visits and reflect an overall orientation toward episodic treatment,* CMS then states that E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries such as those who are returning to a community setting following discharge from a hospital or a skilled nursing facility (SNF). The AAFP fully agrees with these remarks and applauds CMS for directly confronting one of the most pernicious aspects of the current healthcare billing and payment systems.

CMS then proposes to create a G-code that specifically describes “post-discharge transitional care management services.” The code would describe *all non-face-to-face services related to the transitional care management furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from an inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a community mental health center to community-based care.*

As a short term payment strategy, the AAFP is supportive of CMS’s proposal to create this post-discharge transitional care management since its creation is consistent with:

- Prior AAFP [recommendations](#) to CMS to pay separately for non-face-to-face services;
- The general direction of organized medicine, as evidenced by the fact that the AMA’s CPT Editorial Panel has created two new codes for transitional care management, for which the RUC will recommend values in October 2012; and
- The agency’s “triple aim” goals since, as noted in the proposed regulation and in full agreement with the AAFP, *Successful efforts to improve hospital discharge care management and care transitions could improve the quality of care while simultaneously decreasing costs.*

This proposal is an important step, within the restrictions of fee-for-service, toward recognizing the value of the many non-face-to-face services an effective primary care team offers a patient.

In this section, CMS refers to the *community-based physician managing and coordinating a beneficiary’s care in the post-discharge period. We anticipate that most community physicians will be primary care physicians and practitioners.* The expectation that this code would be furnished mainly by primary care physicians is further supported by column E from Table 84 “Proposed Rule Impact on Total Allowed Charged by Specialty by Selected Proposal.” It is thus perplexing that CMS did not propose to restrict the use of this code to actual primary care physicians. The AAFP urges CMS to restrict use of this code to the patient’s primary care physician as identified through use of the [core definitional elements](#) suggested by the AAFP. Should CMS be unable to operationalize these recommendations before 2013, the AAFP would then support the agency restricting use of the newly proposed post-discharge transitional care management service to physicians that are separately eligible for the Primary Care Incentive Program (PCIP).

The AAFP appreciates that this new code is intended to capture both the non-face-to-face work of the physician and *includes non-face-to-face care management services furnished by clinical*

staff member(s) or office-based case manager(s) under the supervision of the community physician or qualified nonphysician practitioner. As envisioned by the AAFP and others, care management under the patient centered medical home (PCMH) is a team effort, and these services will involve not only physician work but also significant practice expenses.

The AAFP supports the proposed description of elements to be included in the new post-discharge transitional care management, since these elements are generally consistent with the definitions that CPT has for its new codes for the same services. We specifically concur that these codes will apply to patients whose problems require moderate or high complexity medical decision making. Despite our overall support, the AAFP offers the following specific comments:

- The AAFP is concerned with references to “business days” in the description of services included under this new code. Traditionally, business days are Monday through Friday, except for holidays. However, many primary care practices are also open on weekends, making those “business days” for those practices. Most importantly, patients’ need for medical care and care coordination is not limited to “business days,” nor are their discharges. Thus, the AAFP recommends that CMS change “business” to “calendar” in this context, which is consistent with CMS’s proposal to define the code as a 30 calendar-day service.
- CMS proposes to require a separately billable face-to-face E/M either within 30 days before or 14 days after discharge. The AAFP agrees with this requirement since it acknowledges that an established relationship with the patient is needed in order to bill the new code. Not only is this sound policy, it also is consistent with the effort to promote continuity of care through a relationship with a primary care physician. However, it is not apparent to the AAFP that a visit 30 days *before* discharge is germane to post-discharge transitional care management; instead, any required visit related to transitional care management needs to occur post-discharge, whether it is within 14, 30, or some other number of days.
- CMS proposes that the required face-to-face visit must be an office or outpatient visit (CPT 99201-99215). However, patients in the post-discharge period may not be healthy enough to travel to a medical office; thus, the AAFP urges CMS to expand the list of acceptable face-to-face visits to include other outpatient visit codes, for example, home visits (99341-99350) and domiciliary/rest home visits (99324-99337).
- The AAFP concurs with the CMS proposal to keep the required post-discharge face-to-face E/M separately reportable, since the level of service will not be the same for every patient. We also agree with the proposal that the new code could not be billed by physicians who bill for discharge day codes or any 10- or 90-day global service to which a discharge is related.

The AAFP supports the proposal to pay this code only once in the 30 (calendar) days following a discharge, per patient per discharge, to a single community based primary care physician (or qualified NPP). However, we have serious concerns with CMS’s proposal to pay only the first claim containing this new G-code that CMS receives for a recently discharged beneficiary 30 days after discharge or thereafter. CMS states that, *Given the elements of the service and the short window of time following a discharge during which a physician or qualifying nonphysician practitioner will need to perform several tasks on behalf of a beneficiary, we believe it is unlikely that two or more physicians or practitioners would have had a face-to-face E/M contact with the beneficiary in the specified window of 30 days prior or 14 days post discharge and have furnished the proposed post-discharge transitional care management services listed above. Therefore, we do not believe it is necessary to take further steps to identify a beneficiary’s community physician*

or qualified nonphysician practitioner who furnishes the post-discharge transitional care management services.

The AAFP disagrees. Many Medicare beneficiaries will suffer from multiple comorbid conditions (consistent with moderate to high complexity medical decision making); thus, these patients are likely utilizing multiple physicians per year. It is quite possible then that the beneficiary may visit more than one physician in either the 30 days prior or 14 days post-discharge. In this scenario, CMS's proposal to pay only the first claim containing the new code creates an uncoordinated race to bill among the various physicians involved, rather than recognizing and rewarding the physician or practice that is actually coordinating the patient's post-discharge care. Thus, as suggested above, AAFP recommends that CMS restrict the use and payment of this code to the patient's primary care physician as identified through use of the [core definitional elements](#) suggested by the AAFP. Should CMS be unable to operationalize these recommendations before 2013, the AAFP would then support the agency restricting use and payment of the newly proposed post-discharge transitional care management service to physicians that are separately eligible for the PCIP.

CMS proposes reimbursement for this new code by utilizing:

- The work RVU of CPT code 99238 (Hospital discharge day management; 30 minutes or less). This results in a proposed work RVU of 1.28. However, CMS states, *We have based the concept of this proposal, in part, on our policy for care plan oversight services.* Those services, G0181 and G0182, each have 1.73 work RVUs. In many respects, the proposed transitional care management code is more analogous to care plan oversight services in terms of physician work, since like those codes, it involves non-face-to-face care management of a patient requiring complex and multi-disciplinary care modalities. The AAFP therefore urges CMS to utilize the work RVUs used for G0181 and G0182 in valuing the new code.
- The clinical labor practice expense inputs for CPT 99214 (Level 4 established patient office or other outpatient visit). This results in a proposed practice expense RVU of 1.41. The AAFP notes that this proposal largely ignores equipment costs (e.g., computer, electronic health record, and telephone) that are essential to providing this service. The AAFP urges CMS to reconsider whether 1.41 is an appropriate practice expense RVU amount.
- The malpractice expense RVUs for CPT 99214, which results in a proposed malpractice expense RVU of 0.09. This is a reasonable crosswalk for the malpractice portion of this service.

The post-discharge transitional care management code, like all other services paid under the physician fee schedule, is subject to a 20-percent beneficiary coinsurance and the Part B deductible. Since this is a new service in 2013, the AAFP is concerned that some Medicare beneficiaries might initially not recognize the beneficiary coinsurance requirement. The AAFP, therefore, urges CMS in 2013 to consider both beneficiary and physician educational materials to increase awareness and use of this new code.

Finally, we want to stress that this proposal should be seen as part of a set of "short-term payment strategies" on the road to a broader primary care payment approach that is a blend of fee-for-service, a per member per month care management fee, and pay-for-performance. The care management fee for the patient-centered medical home (such as with the Comprehensive Primary Care Initiative) is the best

way to handle payment for care coordination and transitions of care. This proposal is a step in the right direction, but it is only a step and not the desired destination.

Section II.H.2. Primary Care Services Furnished in Advanced Primary Care Practices

In the proposed regulation, CMS discusses that if, *in the event that we were to establish an enhanced payment for primary care services furnished to Medicare beneficiaries in an advanced primary care practice environment, we would need to establish a set of parameters to determine whether or not a clinical practice could be considered an advanced primary care practice (medical home)*. CMS proceeds to then invite comments on processes that the agency should consider for application, confirmation that recognized accreditation standards are met, and notification of recognition as a patient centered medical home (PCMH). CMS invites suggestions on methods to recognize practices as advanced primary care practices based on accreditation as a PCMH by one or more of the national accreditation organizations.

The AAFP understands the importance of using the proposed Advanced Primary Care Practice (APCP) framework to ensure that enhanced payments made to primary care physicians are tied to a corresponding expansion of the scope of primary care services to include effective care coordination and continuous quality improvement. The AAFP continues to support CMS's efforts to build ongoing primary care improvement models, such as the proposed APCP program and the Comprehensive Primary Care (CPC) initiative on the established framework of the PCMH. This supports current efforts by primary care physicians to transform their practices into medical homes as well as builds synergy with existing, or soon-to-be implemented, private payer initiatives for adoption of the PCMH model.

The AAFP supports and applauds the use of the five "comprehensive primary care functions," originally mapped out for the CPC initiative, as the basis for development for any Medicare APCP program. The use of the comprehensive primary care functions in a Medicare APCP would ensure that stakeholders across the healthcare industry can develop a better understanding of CMS's support for primary care providers and the expected returns in both quality improvement and cost control. Thus, the AAFP supports the "Markers of Success" for the comprehensive primary care functions identified in this section.

Regarding accreditation and infrastructure, CMS discusses how they could either recognize existing and proven national models for accrediting or recognizing practices as PCMHs or develop their own criteria for accrediting APCPs and oversee the process of administering the accreditation process.

The AAFP believes practices that achieve accreditation or recognition through one of the existing national models should qualify as a Medicare APCP. The AAFP would support this approach for the development of a Medicare APCP program, but we also suggest that CMS develop additional criteria to evaluate APCP participants in order to increase consistency with the five comprehensive primary care functions. The AAFP urges all accrediting entities to take into specific consideration the [Guidelines for Patient-Centered \(PCMH\) Recognition and Accreditation Programs](#) (jointly developed and approved by the AAFP, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association) when reviewing prospective national PCMH recognition/accreditation models for use in a Medicare APCP program. The AAFP encourages CMS to adhere closely to these guidelines

and to continue working with us and the other primary care physician organizations that established the guidelines as the development of Medicare APCP unfolds.

The AAFP shares CMS's interest in structuring any prospective Medicare APCP program so that primary care practices of all sizes and configurations could participate. In developing an APCP program, CMS will need to state clearly the requirements so that participating practices appropriately document their medical home recognition through the agency's Provider Enrollment, Chain, and Ownership System (PECOS) process. To the greatest extent possible, the AAFP calls for the adoption of a streamlined process to reduce the administrative burden for practices seeking to participate.

The AAFP also shares CMS's concerns over requiring practices to purchase proprietary services from a recognized PCMH recognition or accreditation program to become eligible to participate in a Medicare program that is tied to an opportunity for enhanced compensation for primary care services. The AAFP appreciates that CMS recognizes the concern that not all primary care practices can easily afford to invest the upfront costs of attaining recognition or accreditation through one of the models cited in the request for comment.

The AAFP would be less supportive of a CMS approach that develops its own criteria for accrediting APCPs. If CMS were to produce internal criteria for accreditation for a Medicare APCP program, it would help ameliorate concerns shared by the AAFP and CMS about forcing practices to seek accreditation through one of the proprietary national recognition or accreditation models, which require significant costs to the practice. However, the AAFP questions whether primary care physicians would be well served by being forced to wait for CMS to develop a Medicare APCP specific accreditation program rather than being able to continue to capitalize on existing PCMH recognition or accreditation through one of the current national models or on existing investment projections which incorporate moving towards a PCMH transformation. Thus, the AAFP recommends that CMS should give due consideration for building on the current and established framework of PCMH recognition and accreditation models. These programs are already robust, well established in both the private and public sectors, and successfully assess a medical home level of service.

Regarding beneficiary attribution to a PCMH, the AAFP prefers prospective attribution by choice of the beneficiary. This approach is aligned with CMS's emphasis on preserving beneficiary freedom of choice while enabling the PCMH to actively know for which patients it is responsible and will be held accountable.

Section II.B. Potentially Misvalued Codes Under the Physician Fee Schedule

The *Affordable Care Act* expanded CMS' authority to identify, review, and adjust values for potentially misvalued codes with an emphasis on codes that:

- Have grown the most,
- Have experienced substantial changes in practice expenses,
- Are recently established for new technologies or services,
- Are multiple ones frequently billed together in conjunction with furnishing a single service,
- Have low relative values, particularly those that are often billed multiple times for a single treatment,
- Are so-called 'Harvard valued codes,' which have not been reviewed since the implementation of the Resource-Based Relative Value Scale (RBRVS), or

- Are determined inappropriate by CMS.

In the final 2012 Medicare physician fee schedule, CMS consolidated a 5-year review of work and practice expense RVUs into an annual review of potentially misvalued codes and established a process for CMS to accept public nominations of potentially misvalued codes for review coinciding with the release of the annual Medicare physician fee schedule. CMS plans to review malpractice RVUs at 5-year intervals.

In the 2013 proposed regulation, CMS discusses that over 1,000 potentially misvalued codes have been identified and that within 2012, they “intend to enter into a contract to assist us in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the physician fee schedule, both for new and existing services.” Of these identified codes, over 650 are surgical services. Of these 650, CMS completed a review of 450 codes. CMS further discusses that 36 codes were nominated by the public as potentially misvalued. CMS proposes to reduce the procedure time assumptions used in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery, which would more accurately pay for these radiation therapy services. These services have been identified as potentially misvalued by CMS and the Medicare Payment Advisory Commission (MedPAC). In addition, CMS requests the RUC and the public to review these codes and provide valid and reliable alternative data sources to develop appropriate RVU amounts.

Overall, the AAFP is pleased that the agency is utilizing this enhanced authority, and we remain fully committed to assisting CMS and the agency’s contractors in efforts to properly validate relative value units (RVUs) for the identified and potentially misvalued codes.

Within this section, the AAFP specifically supports efforts to improve the valuation of the global surgical package. As noted, the Office of Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS) has found on multiple occasions that surgeons typically furnished fewer evaluation and management (E/M) services in the post-operative period than were identified with the global surgical payment package for each procedure. Even more telling, as CMS notes, is that, *the OIG could only review the number of face-to-face services and was not able to review the level of E/M services that the surgeons furnished due to a lack of documentation in the surgeons’ medical records* [Emphasis added].

The AAFP has long argued that the global surgical packages are inflated in terms of the number and level of post-operative visits that are assumed to be included and incorporated in the value of the codes in question. Also at issue is who is providing these services; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeons focus only on the surgery. Under current Medicare payment rules, these visits would be paid at a discount rate if reported separately by the NPs and PAs (assuming “incident to” was not applicable), yet the visits are valued at the full physician rate in the global surgical package, even when the visits are done in the hospital (where “incident to” does not apply).

The AAFP concurs with CMS commentary that ...*the usual review process does not go far enough to assess whether the valuation of global surgical packages reflects the number and level of post-operative services that are typically furnished*. Thus the AAFP supports CMS’s intent to both investigate this area of potentially misvalued codes and to do so outside the process of the

American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC).

CMS seeks comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. *We are especially interested in and invite comments on a claims-based data collection approach that would include reporting E/M services furnished as part of a global surgical package, as well as other valid, reliable, generalizable, and robust data to help us identify the number and level of E/M services typically furnished in the global surgical period for specific procedures.* The AAFP considers this claims-based approach to be unworkable in the current limitations of the healthcare claims processing infrastructure. It is impractical to require surgeons to report codes that are not going to be paid since the service is part of the global surgical package. Further, this approach will not validate that the services being reported are accurately reported, especially due to the typical lack of documentation in the surgeon's medical records, as noted by the OIG.

The AAFP encourages CMS to properly tackle this legitimate valuation problem and offers two suggestions. One possible approach is that CMS might adjust all surgical services to a 000-day global period, require surgeons to then bill post-operative E/M services separately for payment purposes, and then subject the surgeons to the same coding and documentation standards and audits to which family physicians and other providers that regularly bill E/M services are already subject. The usefulness of this suggestion is arguably limited since the required changes would contribute to CMS's claims processing and utilization review workload and may also increase volume at a time when CMS is emphasizing value.

Alternatively, CMS could draw upon the OIG's more methodical approach and review the medical record for a statistically valid sample of claims (focusing on high volume and/or high dollar surgical procedures) and then extrapolate those results to clinically similar families of codes. This suggestion would require CMS to further invest time and research, but CMS is already mandated to validate existing RVUs, and this approach has the greatest potential to improve the valuation of the global surgical package.

Section II.D. Geographic Practice Cost Indices (GPCIs)

Though CMS did not propose any modifications to the 2013 geographic practice cost indices (GPCIs), the agency did invite comments on the Institute of Medicine's (IOM) Geographic Adjustment in Medicare Payment Phase II: Implications for Access, Quality, and Efficiency [report](#), which was released on July 17, 2012.

As CMS notes in the proposed regulation, the current fee schedule locality structure already disadvantages rural areas, which tend to be underserved. The IOM's recommendation would only further exacerbate these disadvantages, since CMS notes that "[m]any rural areas would see substantial decreases in their corresponding Geographic Adjustment Factor and GPCI values..." As discussed by CMS in the proposed rule and by the IOM in the Phase I and II reports, the IOM recommends increasing the number of GPCI payment areas from 89 to 441. It is AAFP [policy](#) to support the elimination of all geographic adjustment factors from the Medicare fee schedule, except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). Since this IOM recommendation would increase, rather than decrease, the number of payment localities and is thus inconsistent with AAFP policy to move toward a national payment area, we urge CMS to not implement it.

The AAFP urges CMS and the IOM, rather than overly concentrating on data sources and technical accuracy, to instead refocus efforts on ensuring a properly distributed healthcare workforce that is meeting the demands of a growing beneficiary population. The AAFP concurs with Institute of Medicine commentary that, *Medicare payment policies that promote specialization and a large income gap between primary care practitioners and specialists have likely worked at cross-purposes with the objectives of Public Health Service Programs to improve access in underserved areas. As Medicare is the single largest insurance program in the world, the incentives produced by its payment policies may well dominate many decisions made by healthcare providers throughout the United States.*

Similarly, the Institute of Medicine report concludes that the recommendations will *tend to redistribute payments to metropolitan areas from nonmetropolitan areas, including some that historically have been underserved.* Thus, the AAFP encourages CMS and the IOM to hold off implementation of any recommendation until CMS can at least develop a plan to hold high-need areas harmless.

Section II.E. Medicare Telehealth Services

The AAFP supports the agency's proposals to add these recently covered "additional preventive services" to the list of Medicare telehealth services for 2013:

- G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15 to 30 minutes;
- G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention greater than 30 minutes;
- G0442: Annual alcohol misuse screening, 15 minutes;
- G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes;
- G0444: Annual Depression Screening for adults, 15 minutes;
- G0445: High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semiannually, 30 minutes;
- G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes;
- G0447: Face-to-face behavioral counseling for obesity, 15 minutes;

CMS notes that all coverage guidelines continue to apply when these services are furnished via telehealth, and discusses that, *...when the national coverage determination requires that the service be furnished to beneficiaries in a primary care setting, the qualifying originating telehealth site must also qualify as a primary care setting. Similarly, when the national coverage determination requires that the service be furnished by a primary care practitioner, the qualifying primary distant site practitioner must also qualify as primary care practitioner.* The AAFP concurs with this approach and intends to partner with CMS to help educate physicians about these preventive telehealth services newly available in 2013.

Section II.J. Payment for New Preventive Services HCPCS G-Codes

The AAFP is pleased that the *Affordable Care Act* authorizes CMS to add coverage of "additional preventive services" if certain criteria are met, and thus, the AAFP supports Medicare coverage of the preventive services listed in Table 23. However, the AAFP questions several of the

proposed payment amounts on what appear to be inappropriate crosswalks. To ensure proper payment amounts, the AAFP recommends that CMS subject these codes to a multi-specialty refinement panel or ask the RUC to make a recommendation:

- G0442 crosswalk to 99211: G0442 includes 15 minutes of physician time, while 99211 only includes 7 minutes (total time). If CMS wants to compare physician time to an office-based E/M, the AAFP recommends using 99212, which has 16 minutes total physician time and 0.48 work RVUs compared to the 0.18 work RVUs for 99211. Another comparable code would be 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes), which includes 20 minutes of physician time and 0.65 work RVUs, so a corresponding work RVU for 15 minutes would be 0.49, similar to 99212.
- G0443 crosswalk to 97803: CMS proposes 0.45 work RVUs for 15 minutes. In reality, if a physician spent 15 face-to-face minutes counseling a patient on alcohol misuse, the physician could potentially report 99213 based on time. Code 99213 has 0.97 work RVUs, which makes G0443 seem undervalued at 0.45 for the same time.
- G0444 crosswalk to 99211: G0444 includes 15 minutes of physician time. This is undervalued for the same reasons as G0442, above.
- G0445 crosswalk to 97803: G0445 includes 30 minutes of physician work. Code 97803 only has 17 minutes. So, based on time, G0445 should be about twice as much as 97803, or 0.90 work RVUs. Compare G0445 (30 minutes of high-intensity behavioral counseling) to 99402 (preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes) and a published RVU of 0.98. Both comparisons support a work RVU at or above 0.90 for 30 minutes of physician time, which is twice the 0.45 proposed by CMS.
- G0446 crosswalk to 97803: G0446 is proposed to have 15 minutes of physician time, which is comparable to the time of 97803. Code 99407 (tobacco cessation counseling, more than 10 minutes) has 15 minutes and 0.50 work RVUs, so CMS's proposal for this code is understandable, although still much less than if 99213 was coded based on 15 minutes of counseling.
- G0447 to 97803: This is undervalued for the same reasons as G0446.

Section III.C. Durable Medical Equipment Face-to-Face Encounter

The *Affordable Care Act* requires that a physician has a face-to-face encounter with a beneficiary during the six-month period prior to a written order for certain Medicare-covered durable medical equipment. In the proposed regulation, CMS suggests changing the six-month requirement to no more than 90 days before the order is written or within 30 days after the order is written.

The AAFP largely considers the proposal to have the face-to-face visit within 90 days before or 30 days after the order is written as reasonable. We appreciate that CMS limits this requirement to durable medical equipment and excludes prosthetics and orthotics. However, the AAFP finds it problematic that CMS did not propose to supersede existing regulations that more specifically address face-to-face requirements for particular durable medical equipment items. For example, power mobility devices have a 45-day window for the face-to-face visit. The AAFP encourages CMS to establish more uniformity in these processes, since different standards for specific durable medical equipment will create confusion and errors.

Regarding the requirement that physicians document the face-to-face service performed by a non-physician practitioner, the AAFP prefers Option 2 as outlined by CMS. In this option, the

physician signs or cosigns the pertinent portion of the medical record for the beneficiary for the date of the face-to-face encounter, thereby documenting that the beneficiary was evaluated or treated for a condition relevant to an item of durable medical equipment on that date of service. This option would provide evidence that the physician has reviewed the relevant documentation to support a face-to-face encounter for that date of service. A signed order by the physician alone would not satisfy the requirement described in this option that the physician “sign/cosign the pertinent portion of the medical record.”

The AAFP appreciates and supports CMS’s proposal to reimburse physicians with \$15 by way of a newly proposed G-code for documenting that a non-physician practitioner performed the necessary face-to-face visit. This payment will help to defray costs the practices will incur when they provide documentation to the durable medical equipment supplier. However, the AAFP is troubled by the proposal that, *Only a physician who does not bill an E/M code for the beneficiary in question would be eligible for this G-code.* This language ignores the situation in which a physician performs an unrelated E/M code, and the non-physician practitioner performs the durable medical equipment-related face-to-face E/M on another occasion in the same timeframe. AAFP urges CMS to reconsider the limitations placed on use of this new G-code.

Though the AAFP understands that CMS must impose this requirement on physicians to meet statutory requirements, the AAFP nevertheless objects to policies that coerce physicians into functioning as a safeguard against fraud and abuse. Requirements like this serve no legitimate medical purpose; rather, they are designed solely to help CMS protect the Medicare trust funds. Though this is a worthy and important cause, it should not interfere with the medical care physicians strive to provide their patients.

Section III.G. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

In general, the AAFP acknowledges and appreciates that CMS did not make any wholesale changes in the PQRS and that the agency proposes to continue most of the program uninterrupted. The changes that are proposed seem intended to facilitate physician participation in advance of the penalty that begins in 2015.

The AAFP continues to support quality improvement efforts, and we share the agency’s goal of increasing successful participation in the PQRS. Given the current low participation rate in the PQRS, the AAFP finds it especially important to offer physicians as many ways as possible to avoid the penalty in 2015. For instance, the AAFP appreciates the addition of an optional and voluntary administrative claims-based reporting mechanism for the 2015 and 2016 adjustments. Likewise, the AAFP supports the addition of the 6-month reporting period (July 1 – December 31, 2013) for the 2015 payment adjustment for the reporting of measures groups via registries.

The AAFP strongly supports all proposals to align further the reporting criteria under the individual PQRS quality measures via electronic health record and the clinical quality measures component of the Medicare/Medicaid Meaningful Use programs. Similarly, the AAFP appreciates CMS’ attempts to align the reporting requirements under PQRS with those related to the value based payment modifier. Since PQRS and value based payment modifier penalties loom on the horizon, the AAFP fully supports the CMS proposal to apply the same criteria for satisfactory reporting for the 2015 and 2016 payment adjustments as those proposed for the 2013 and 2014 incentives. Increasing consistency over time and alignment with other programs are worthwhile.

The AAFP also concurs with the CMS proposal to establish an informal review related to payment adjustment. The time frame (60 days into adjustment period) seems reasonable.

Despite our support for quality improvement efforts, it continues to astonish the AAFP that CMS proposes to penalize physicians in a given year for something that the physician failed to do satisfactorily two years before. Penalties and rewards need to be proximate to the behavior being penalized or incentivized to be effective. For PQRS participation rates to improve, CMS must be more efficient and effective in administering the system in a way that avoids 12- or 48-month lags. As outlined by the AAFP in a [letter](#), dated January 19, 2011, the AAFP recommends that CMS phase out the claims-based reporting option. Since it was not designed to support quality reporting, claims-based reporting has been problematic from the start of the PQRS program. The complexity of the claims-based reporting system causes frequent reporting errors. Further, a more real-time process would eliminate or significantly decrease the problem associated with changes in group practices as discussed in this section.

CMS proposes to change the definition of group practice from 25 or more providers to 2 or more providers. This is certainly consistent with how the AAFP understands the term “group practice,” although the AAFP is concerned with the use of the term “eligible professional” in this context rather than “physician.” If finalized as proposed, a solo family physician whose practice includes a nurse practitioner would theoretically be considered a “group practice” for purposes of the PQRS. Solo physicians should not be considered group practices or compared with groups of physicians.

The AAFP also disagrees with CMS’s continued insistence that eligible professionals may not submit quality data codes on claims that were previously submitted and processed. The AAFP finds this perplexing since CMS would certainly accept and reprocess a claim if it impacted payment for any other reason. Why not then for PQRS purposes?

The AAFP worries about CMS’s proposals to post the final list of PQRS registries qualified for each reporting period by the summer of each reporting period. This creates a problem for practices relative to choosing among multiple reporting options, especially as CMS moves to only 12-month reporting periods. How is a practice to decide among reporting options for a given reporting period if it does not know until mid-year of the reporting period what the registry options are?

Section III.H. Electronic Prescribing (eRx) Incentive Program

From 2009 through 2013, CMS is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to a percentage of the eligible professional's total estimated Medicare Part B physician fee schedule allowed charges for all covered professional services furnished by the eligible professional during the respective reporting period.

For years 2012 through 2014, CMS will apply a payment penalty to eligible professionals who are not successfully electronic prescribing. The applicable eRx percent for payment incentives and penalties under the eRx Incentive Program are as follows:

- 2011: 1.0 percent incentive for successful electronic prescribers.
- 2012: 1.0 percent incentive for successful electronic prescribers or 1.0 percent penalty for non-successful electronic prescribers.

- 2013: 0.5 percent incentive for successful electronic prescribers or 1.5 percent penalty for non-successful electronic prescribers.
- 2014: 2.0 percent penalty for non-successful electronic prescribers.

The requirements for the 2013 eRx incentive and 2013 and 2014 eRx payment adjustment (i.e., penalty) were established in the 2012 Medicare physician fee schedule final rule. Also in the 2012 final rule, CMS finalized four circumstances under which an eligible professional or eRx Group Practice Reporting Option (GPRO) can request consideration for a significant hardship exemption for the 2013 and 2014 eRx payment adjustments, these are:

- The eligible professional or group practice practices in a rural area with limited high speed internet access.
- The eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.
- The eligible professional or group practice is unable to electronically prescribe due to local, state, or Federal law or regulation.
- The eligible professional or group practice has limited prescribing activity, as defined by an eligible professional generating fewer than 100 prescriptions during a 6-month reporting period.

Within the confines of the 2013 proposed regulation, the AAFP supports the CMS proposal to create new criteria for being a successful electronic prescriber for groups of 2-24 eligible professionals using the eRx GPRO. The AAFP also supports the proposal to establish an informal review process.

CMS also proposes two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program. These new hardship exemptions are:

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods. The AAFP supports offering additional ways for physicians to avoid payment penalties. However we note that this exemption only applies to Meaningful Users who did not receive an EHR incentive payment for 2011 and who started their 2012 meaningful use "reporting period" before April 3, 2012. Since the electronic prescribing requirement under Meaningful Use is much more stringent than under the eRx program, the AAFP recommends that CMS allow all Meaningful Users from 2011 and 2012 to be eligible for this exemption.
- Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology. The AAFP also supports offering this additional exemption, though we note that this exemption requires eligible professionals to "register" for the meaningful use program and provide a code number for their "Certified EHR Technology" before requesting an exemption on Oct. 15, 2012. This well-intended proposal creates a group of eligible professionals (yet to become meaningful users) that would be exempted from the eRx penalty and a group of actual meaningful users that would be subject to the eRx penalty (presuming no G-codes are submitted to CMS). The AAFP urges CMS to address this discrepancy.

Both of the newly proposed exemptions require an active request on the part of the eligible professional. This proposed requirement provides CMS with no additional information to determine the physician's right to the exemption. Since CMS bases the exemption on data that they have already collected from the eligible professional, the AAFP urges CMS to alter these exemptions such that the eRx penalty exemption becomes "automatic" rather than require any additional effort by individual eligible professionals.

Section III.I. Medicare Shared Savings Program

The AAFP supports the four PQRS related requirements included in the Medicare Shared Savings Program (MSSP) final rule, specifically the AAFP supports the:

- Use of the 22 Group Practice Reporting Option (GPRO) quality measures outlined in Table 1 of the final MSSP rule
- Reporting via the GRPO web interface
- Criteria for “satisfactory requirements”
- Implementation of a calendar year based reporting period.

The AAFP supports initiatives, such as PQRS, that continue to push for quality improvement across the healthcare delivery system. However, the AAFP opposes implementation of initiatives that place an unproductive requirement for documentation and other administrative burdens on physicians insofar as these conditions will ultimately detract from a primary care physician’s ability to provide meaningful patient care.

To this end, the AAFP strongly supports CMS’s proposed efforts to streamline the implementation of the PQRS incentive and reporting programs within the context of the MSSP. Removing as much of the burden from individual physicians to participate in the MSSP related PQRS programs will serve to make participating in these important quality tracking and improvement initiatives more attractive and more achievable for primary care physicians interested in, but unsure of, providing care in an MSSP Accountable Care Organization (ACO).

For purposes of the PQRS payment adjustment, the AAFP supports the proposal to incorporate the same PQRS GPRO rules used for the MSSP. Furthermore, the AAFP supports CMS’s proposal to accept PQRS data reported at the level of the MSSP ACO rather than requiring each eligible ACO provider and supplier to submit individual PQRS measures via the GPRO web interface. The AAFP also supports the provision that eligible ACO provider and suppliers would avoid being subject to the PQRS payment adjustment beginning in 2015 as long as the MSSP ACO under which they provide care has submitted PQRS data, as defined by the ACO GPRO measures outlined in the MSSP final rule.

Finally, the AAFP applauds CMS’s ongoing commitment to ensuring the maximum flexibility for eligible physicians by modeling an approach for fulfillment of the PQRS reporting requirements that addresses the reality that physicians may decide to move in or out of a given MSSP ACO from year to year.

Section III.K. Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program

The *Affordable Care Act* calls for CMS to establish a value-based payment modifier that provides for differential payment to a physician or group of physicians under the Medicare physician fee schedule based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires CMS to begin applying the value-based payment modifier in 2015, and to apply it to all physicians and groups of physicians beginning not later than January 1, 2017. The statute also requires that the value-based payment modifier be implemented in a budget-neutral manner, meaning that the increases in payments for some physicians or groups of physicians directly relates to the amount decreased in payments for other physicians or groups of physicians.

So the agency can begin learning how to properly fulfill the statutory requirements, the AAFP mostly supports CMS proposal to begin applying the value-based payment modifier only to groups of 25 or more eligible providers in 2015. In this context, the AAFP offers general support to the CMS principles regarding implementation of the physician value-based payment modifier, and the AAFP concurs with the discussion outlined in *“A focus on physician choice”* and *“A focus on gradual implementation.”* Considering the two-year lag between data reported (2013) and action taken (2015) and since two-year old data is not actionable or meaningful in any way, the AAFP urges CMS to further explore ways to realistically achieve principles cited in *“A focus on actionable information.”*

The AAFP remains concerned with CMS’s inability to specify the exact amount of the upward payment adjustment because of budget neutrality considerations. It will be challenging for groups to make reasonable business decisions on whether or not to subject themselves to a new and untested quality tiering system without prior knowledge of a potential reward.

CMS proposes to apply the value-based payment modifier only to items or services billed by eligible professionals who are physicians, even though they are counting all eligible professionals for purposes of determining group size. The AAFP finds this proposal to be uneven and inconsistent. CMS instead ought to exclude non-physicians when determining group size and apply the modifier to all eligible professionals within a medical group practice since the AAFP believes that high quality and coordinated care (as envisioned in a patient centered medical home) is a team effort.

Consistent with the focus on gradual implementation, the AAFP deems it premature in this first year to calculate the value-based payment modifier for all groups that are satisfactory PQRS reporters using the quality-tiering approach, rather than making it just an option for such groups to request. Instead, we support CMS’s proposal to give groups that are satisfactory reporters the option of quality-tiering, without requiring that they subject themselves to such, especially since, as noted, the potential upward adjustment is unknown.

At the same time, it strikes us that applying a -1.0% penalty under value-based payment modifier to those groups who do not satisfactorily report under PQRS (either because they did not participate or did not participate satisfactorily) amounts to penalizing those group practices twice for the same thing, or otherwise doubling the statutory penalty for failure to satisfactorily report under PQRS. That does not seem fair or authorized under the statute.

We note that calculation of administrative, claims-based, quality and cost measure performance rates requires CMS to attribute Medicare beneficiaries to groups of physicians. To attribute beneficiaries to physicians, CMS proposes to use “plurality of care” when calculating the value-based payment modifier. This method attributes Medicare beneficiaries to the group practice that billed a larger share of office and other outpatient E/M services (based on dollars) than any other group. CMS also discusses using “degree of involvement” as an alternative. This method was used to attribute beneficiaries for cost purposes to individual physicians in the 2010 Physician Feedback reports, which CMS produced for physicians (23,730 physicians in total) in Iowa, Kansas, Missouri, and Nebraska. Under this attribution method, CMS classified the patients for which a physician submitted at least one Medicare Part B claim into three categories (directed, influenced, and contributed) based on the amount of physician involvement with the patient. Since plurality of care aligns with the existing PQRS GPRO attribution method, the AAFP finds it

preferable from that perspective. However, degree of involvement seems more comprehensive and a better alternative in the long run. We would encourage CMS to further explore the potential impact of these alternative methods by applying each to the same sample of beneficiaries and observing the results. We would also encourage CMS to share those results in future rulemaking as it considers these options in the future.

Finally, related to the impact on beneficiaries, we note that the modification, as proposed, applies only to the Medicare paid amount, so as not to affect beneficiary copayments and deductibles. We understand this approach and support the proposal not to penalize beneficiaries who use the services of high quality/low cost providers. At the same time, we would ask CMS to consider that if beneficiaries are isolated from the impact of value-based purchasing in any way, what will incentivize them to use high quality/low cost practices? We would encourage CMS to address this aspect of value-based purchasing in the future.

Section III.L. Medicare Coverage of Hepatitis B Vaccine

The AAFP fully supports the agency's proposal to begin Medicare Part B coverage of the Hepatitis B vaccine for high risk groups, specifically persons with diabetes. The AAFP's current adult immunization [schedule](#) recommends vaccinating any person with medical indications or any person seeking protection from Hepatitis B. The inclusion of Hepatitis B immunizations in Medicare Part B coverage would help facilitate increased immunization rates for this population and we are thus pleased with this proposal.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Roland A. Goertz". The signature is written in a cursive, somewhat stylized font.

Roland A. Goertz, MD, MBA, FAAFP
Board Chair