



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

August 26, 2015

Andy Slavitt,  
Acting Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Ave., SW  
Washington, DC 20201

Dear Administrator Slavitt,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the [2016 proposed Medicare physician fee schedule](#) as published in the *Federal Register* on July 15, 2015. This response is in addition to the AAFP's July 23, 2015, [letter](#) that congratulated the Centers for Medicare & Medicaid Services (CMS) and outlined our full support for the proposed creation of advance care planning services.

The AAFP recognizes this is the first proposed physician fee schedule after repeal of the Sustainable Growth Rate (SGR) formula by the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*. The 2016 proposed fee schedule marks the first time in many years that physicians do not face significant and disruptive cuts in their Medicare payment because of the flawed SGR formula. The AAFP looks forward to working with CMS to develop new, MACRA required payment systems for physicians and other practitioners.

To improve the final 2016 Medicare physician fee schedule rule, in summary the AAFP:

- Supports technical changes to the methodology used to compute the practice expense and malpractice relative value units (RVUs).
- Appreciates CMS's efforts to identify misvalued services and comments on how to improve the valuation and coding of the global surgical package.
- Supports the permanent elimination of the refinement panel, since CMS will instead publish information separately.
- Appreciates CMS's interest in better valuing cognitive work outside of the current evaluation and management (E/M) code framework but strongly urges CMS to revalue E/M codes before creating new add-on codes for E/M services.
- Suggests ways CMS can improve beneficiary access to transitional care management (TCM) and chronic care management (CCM) services.
- Discusses the proposed methodology CMS will use to compute RVU adjustments for misvalued services as well as how the agency will phase-in significant RVU reductions.
- Reiterates full support for the CMS proposal to pay for advance care planning (ACP) services in 2016.

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- Supports the inclusion of CPT codes 99356-99357 (prolonged services in the inpatient or observation setting) on the telehealth list but expresses concerns with the proposed frequency limitation.
- Supports the incident-to clarifications made by CMS.
- Fully supports CMS paying for CCM services in rural health clinics and federal qualified health centers.
- Expresses significant concerns about the disproportional burden primary care physicians will face in 2017 when trying to comply with a requirement that physicians ordering certain imaging services (magnetic resonance, computed tomography, nuclear medicine, and positron emission tomography imaging services) for Medicare beneficiaries must consult appropriate use criteria applicable to the imaging modality.
- Is supportive of the Physician Compare website concept but with several concerns regarding the complexity and accuracy of the information and its usefulness to consumers. The AAFP also strongly urges CMS to incorporate the Core Quality Measures Collaborative's aligned measure sets.
- Opposes the premature expansion of Clinician and Group-Consumer Assessment and Healthcare Providers and Systems (CAHPS) survey to 25+ eligible professionals reporting via the Group Practice Reporting Option (GPRO) since the mandate to use a CAHPS certified vendor comes with great expense and is resource intensive, especially for smaller practices.
- Supports the proposal to allow more time for qualified clinical data registries (QCDR) to self-nominate.
- Comments on low-volume threshold and clinical practice-improvement activities associated with the Merit-Based Incentive Payment System (MIPS) and outlined AAFP suggestions regarding how the agency should develop Alternative Payment Models (APMs).
- Supports further reporting alignment between the Electronic Health Record (EHR) Incentive Program and Comprehensive Primary Care (CPC) initiative.
- Strongly urges CMS to expand the CPC initiative to as many geographic regions and practice sites as possible.
- Comments on the further development of the Value-Based Payment Modifier and Physician Feedback Program.

#### II.A. Determination of Practice Expense (PE) Relative Value Units (RVUs)

CMS proposes several technical changes to the methodology used to compute the PE RVUs for codes and also seeks input on publicly available data sources to improve the accuracy of equipment costs used in developing PE RVUs. CMS also proposes changes to the direct PE inputs for services focused on radiology/imaging, pathology, orthopedics, ophthalmology, and otorhinolaryngology. The AAFP reviewed the proposed changes and finds them to be rational and supportable. We applaud CMS for exploring and using such additional data sources beyond the usual RUC valuation process.

#### II.B. Determination of Malpractice Relative Value Units (RVUs)

CMS has conducted a review of malpractice (MP) RVUs every five years. Starting in 2017, CMS proposes to begin conducting annual MP RVU updates to reflect changes in the mix of practitioners providing services, to adjust MP RVUs for risk, and to make other methodology changes. The AAFP reviewed the technical changes to the MP RVU methodology and finds them reasonable.

### II.C. Potentially Misvalued Services Under the Physician Fee Schedule

The AAFP continues to appreciate and support CMS's efforts to identify misvalued services and make appropriate adjustments in order to pay all physician services more accurately. Accordingly, the AAFP supports CMS's proposals and justifications to adjust the codes in Table 8 as a way to more accurately pay for physician services.

Within this section of the proposed rule, CMS seeks guidance on how to improve the valuation and coding of the global surgical package while simultaneously adhering to Section 523 of the *Medicare Access and CHIP Reauthorization Act (MACRA)*. That section of *MACRA* otherwise prohibits CMS from implementing AAFP-supported policy that CMS had established in the 2015 final Medicare physician fee schedule. Specifically, CMS policy would have transitioned all 10-day and 90-day global surgery packages to 0-day global periods. However, *MACRA* prohibits the unbundling of the global surgical codes and requires CMS to develop a process, no later than 2017, to gather information needed to value surgical services from a representative sample of physicians.

CMS now solicits comments regarding the:

- Types of auditable, objective data needed to increase the accuracy of the values for surgical services.
- Most efficient means of acquiring this data as accurately and efficiently as possible.
- Potential methods of valuing the individual components of the global surgical package, including the procedure itself, and the pre- and postoperative care, including the follow-up care during post-operative days.
- Overall accuracy of the values and descriptions of the component services within the global packages.
- Differences (both qualitatively and quantitatively) between post-operative visits from other evaluation and management (E/M) services.
- Other items and services related to the surgery, aside from post-operative visits, that are furnished to beneficiaries during post-operative care.

The AAFP sent CMS letters on [February 20, 2013](#), and [August 26, 2014](#), detailing our position that global surgical packages are inflated in terms of the number and level of post-operative visits assumed to be included and incorporated in the value of the codes in question. We also noted that the current arrangement leads to unwarranted payment disparities in PE values between E/M services in a global surgical package and stand-alone E/M services. We note that who is providing these services is an issue; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeon focuses only on the surgery itself. Under current Medicare payment rules, such visits would be paid at a discounted rate if reported separately by the NPs and PAs (assuming "incident to" rules were not met); however, these visits are valued at the full physician rate in the global surgical package, even when the visits take place in a hospital (where "incident to" does not apply). We continue to believe that the current global surgical packages are incompatible with current practice and provide unreliable building blocks for new payment methodologies. Accordingly, the AAFP appreciates that CMS continues its efforts to pay accurately for these services.

Regarding auditable and objective data, the AAFP believes captured data should include:

- The length (in minutes) of the procedure;
- Whether the surgeon actually visits the patient later on the same day of the procedure;
- The number and type of visits and other services furnished in the hospital during the post-operative period (where applicable);
- The number and level of office visits and other outpatient services furnished during the post-operative period;
- Who is actually furnishing the post-operative hospital and office services and whether those are being done “incident to” when done by someone other than a physician. The AAFP believes this piece of information is especially crucial.

Regarding the length of the procedure, it would seem that this data should be readily available from hospital operating logs or anesthesia services billed to Medicare (since anesthesia is billed in units based on time). The AAFP encourages CMS to access these and other existing data sources while studying global surgical codes for purposes of paying more accurately for these services. These are important sources of objective data which are not part of the usual RUC process but are likely more accurate.

In terms of other data elements, Section 523 requires CMS to collect information from a representative sample of physicians and that, “Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary.” The AAFP interprets this to mean that all of the surgeons in the sample would need to report all of their post-operative visits and other services using codes that identified the level of service with the rendering provider identified by national provider identifier (NPI) on the claim. The AAFP strongly encourages CMS to require the NPI of the provider actually providing the service, even if done “incident to.” This would give CMS insightful data on who is actually providing the post-operative service in each case. The surgeons in the sample can report these post-operative visits and other services using the existing Current Procedural Terminology (CPT) codes with a Healthcare Common Procedure Coding System (HCPCS) modifier created by CMS to denote the service is being reported for this purpose and not for payment, since the surgeons will still be receiving global surgical payments. As CMS continues this important and necessary effort to improve the accuracy in the valuation of global surgical codes, the AAFP encourages CMS to audit the charts for a representative sample of such claims to ensure the data reported is accurate and that the level of E/M services claimed also appropriately adheres to E/M documentation guidelines.

Though the AAFP ultimately supports CMS’s research efforts surrounding the proper payment for surgical and post-operative services, we also express concern that collecting data as proposed may be susceptible to the Hawthorne effect. Practices that are participating in a representative sample will know when they bill global surgical codes that they are being observed and thus may alter their actions due to such awareness. One way to counteract this effect, consistent with our next suggestion, is to ensure that the representative sample is a random one and that the data collected is from a period of time prior to when CMS draws the sample.

The AAFP continues to believe a more accurate understanding of current practice could be exposed through random and retroactive chart audits of services provided up to 2015. Though the results might be more accurate, the AAFP recognizes this method could also be less efficient. However, the AAFP

nevertheless urges CMS to invest a portion of the already-allocated research funding into retrospective chart audits to help avoid the possibility of future coding being altered due to awareness of a CMS study.

CMS requests qualitative and quantitative information on whether postoperative visits differ from other E/M services. The AAFP encourages CMS to consider Dr. David Katerndahl's [work](#) "Complexity of ambulatory care across disciplines," which notes that, "The work relative value unit (RVU) assigned to ambulatory visits is identical across specialties with the assumption that the work is equivalent for each specialty. This assumption is faulty." His research suggests that postoperative visits do not differ from other E/M services within a given specialty, although E/M services do differ significantly among specialties, with surgical specialties being on the low end of the complexity-density scale. The AAFP believes this research could be most valuable to CMS in correctly assessing the value of these global surgical services and codes as well as to CMS's on-going efforts to better value primary care services.

#### II.D. Refinement Panel

Since 1993, CMS has used a refinement panel process to assist in reviewing public comments on CPT codes with interim final work RVUs for a year and in developing final work values for the subsequent year. CMS now proposes to permanently eliminate the refinement panel and instead publish the proposed rates for all interim final codes in the proposed rule for the subsequent year. This proposal is consistent with the change in the process for valuing codes adopted in the 2015 final rule with comment period. Under that change in process, CMS will publish proposed values for most codes that CMS is valuing for a given year in the proposed rule for that year's fee schedule.

The AAFP supported the changes made in the 2015 final rule. We also support changes CMS now proposes and appreciate that CMS will publish the proposed rates for all interim final codes in the proposed rule for the subsequent year.

#### II.E. Improving Payment Accuracy for Primary Care and Care Management Services

The AAFP appreciates that CMS reiterates a commitment to supporting primary care, and the AAFP acknowledges the recent CMS initiatives designed to improve the accuracy of payment for and encourage long-term investment in primary care and care management services. Like CMS, we feel more can be done to improve primary care payments and to refine the accuracy of all Medicare payments.

##### *1. Improved Payment for the Professional Work of Care Management Services*

CMS is interested in feedback on ways to recognize cognitive work involved in delivering broad-based and ongoing treatment beyond resources already incorporated in the codes that describe the broader range of E/M services. CMS is particularly interested in codes that could be used in addition to, not instead of, the current E/M codes. CMS would require that the patient have an established relationship with the billing professional, and the use of an add-on code would require the extended professional resources to be reported with another separately payable service. However, the new codes might be reported based on the resources involved in professional work, instead of the resource costs in terms of clinical staff time.

CMS also is interested in comments on the kinds of services that involve the type of cognitive work described above and whether or not the creation of particular codes might improve the accuracy of the relative values used for such services under the Medicare physician fee schedule. Finally, CMS is interested in receiving information on the overlap between the kinds of cognitive resource costs discussed

above and those already accounted for through the currently payable codes that describe CCM and other care management services.

The AAFP appreciates CMS's interest in better understanding and valuing cognitive work performed by physicians outside of the current E/M code framework. However, the idea of creating add-on codes for the current E/M codes is like building an addition onto a house with a very poor foundation. As the AAFP has articulated to CMS in the past, several significant concerns exist with the established E/M codes and associated documentation guidelines. These include:

- Overemphasis on traditional histories and physicals, possibly overlooking the importance of physician knowledge and expertise;
- Lack of recognition of the importance of complexity of conditions presented by patients and the resultant complexity of decision-making, need for shared decision-making, counseling, patient education, etc.
- Possible role of coding as a factor in generating well-documented specialty income differences;
- Effect of coding limitations on clinical practice, possibly leading physicians to do activities of relatively less value and omitting others that are not included in code definitions;
- Disconnect between codes and documentation guidelines on one hand and evolving care models on the other, with codes and documentation guidelines not reflecting practice redesign developments such as the increased role of teams in primary care;
- Incentives to "up-code" inherent in code design; and
- Mixed evidence on the concordance of service times across specialties and with code definitions.

Additionally, the AAFP advocates what Dr. Katerndahl's work demonstrates, which is the current outpatient E/M codes mask a wide spectrum of services, which often vary by physician specialty. The AAFP believes several factors affect the appropriateness and effectiveness of visit codes:

- *Basis of payment*--It must be possible to value a service for payment within the prevailing payment system.
- *Clinical congruence*--Codes must align sensibly with clinical activities and avoid creating incentives to distort the amount of time spent with patients or the way that time is used in order to justify use of a particular code.
- *Administrative burden*--Proper code assignment and documentation cannot create undue burden for physicians, patients, or claims processing.
- *Program integrity*--There needs to be clarity for proper coding to minimize the chance of payment errors, the incentives to 'up-code,' and the possible implications for patient access to care.

The AAFP strongly believes that the current outpatient E/M codes fail on all four counts. Since E/M codes contain a wide array of services that are encompassed by such a finite number of codes, these codes are difficult, if not impossible, to value accurately. Furthermore, current outpatient E/M codes are not clinically congruent with the way in which primary care is practiced in the 21<sup>st</sup> century. The current system creates documentation and code-assignment hassles for physicians and program integrity challenges for CMS.

The AAFP, therefore, strongly urges CMS to fix the foundation before creating new add-on codes for E/M services. Ironically, in the proposed rule, CMS states, "We agree with stakeholders that it is important for

Medicare to use codes that accurately describe the services furnished to Medicare beneficiaries and to accurately reflect the relative resources involved with furnishing those services.” Yet, CMS seems unwilling or unable to recognize this means tackling the fundamental problem, which is that E/M codes do not accurately describe the services furnished to Medicare beneficiaries and do not accurately reflect the relative resources involved with furnishing those services.

Thus, the AAFP strongly encourages to CMS to undertake on its own through its ability to create Level II HCPCS codes (or perhaps by engaging the CPT Editorial Panel) an effort to thoroughly redefine the outpatient E/M codes (99201-99215) leading to codes that better describe such services and more accurately capture the resources involved in providing them, especially for primary care. While there are E/M deficiencies throughout the fee schedule, the AAFP believes outpatient E/M codes must be addressed first, because they make up a significant portion of Medicare physician fee schedule billings.

The AAFP fully understands that committing to a complete redesign of office-visit codes within CPT would require extensive development work, especially since there is neither a clear alternative code set currently available nor is there consensus on what the new codes should be. Presumably, a complete overhaul would be done to explicitly improve clinical congruence within the construct of the Medicare physician fee schedule payment structure in a way that minimizes administrative burden to both physicians and payers while improving and not threatening program integrity. While there is no guarantee in the results of such an effort, the AAFP strongly believes that current problems with payment accuracy for primary care services will persist if CMS continues using the same E/M codes, even with a structure of supplementary cognitive add-on codes. It is urgent for CMS to redefine and revalue office-visit codes to assure that current payment imbalances do not become actuarially embedded in future APMs.

A more accurate approach to creating new outpatient E/M codes would be derived from a research-based model. The model, in turn, would be developed by studying the work done by physicians across the country before, during, and after E/M services. If successful, this research-based model could then be used to address the deficiencies in the other E/M code families. We urge CMS to consider underwriting this research by hiring an expert contractor to work with stakeholders to develop a comprehensive understanding of outpatient E/M work physicians and their clinical staff currently performs. This research would:

- Describe in detail the full range of intensity for outpatient E/M services
- Define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion
- Develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making
- Provide efficient and meaningful guidance for documentation and auditing
- Ensure accurate relative valuation as part of the physician fee schedule

Such research will also be critical to identifying and valuing the uncompensated work associated with E/M services that the agency otherwise intends to support with add-on codes. This research will provide the agency with an accurate and reliable description of E/M activities. It will also help clarify what physician work should be attributed to the E/M services and allow a clear definition of what Medicare should expect from CCM and TCM services. We will gladly provide added support to any contractor hired to pursue this

needed research, and we will be pleased to serve as a resource for the agency in its efforts to ensure accurate service code definitions and valuations.

However, if CMS is resolved to create add-on codes for E/M services, the AAFP encourages the agency to first re-examine the existing E/M codes that the agency does not pay for separately. For example CMS should consider separate payment for these services:

- Telephone consultation E&M by physician, 99441-99443
- Telephone consultation E&M by non-physician, 98966-98968
- Online medical evaluation, 99444, 98969
- Medical team conference, 99366, 99367, 99368
- Collect/review data from patient (add-on), 99090
- Anticoagulation management, 99363-99364
- Prolonged services without direct patient contact, 99358-99359
- Interprofessional telephone/internet consultations, 99446-99449

Another, non-mutually exclusive option CMS should consider in the spirit of improving payment accuracy for primary care and care management services is to earnestly re-examine the current documentation guidelines for E/M services. The AAFP believes CMS should conduct a study of the impact of the documentation guidelines on both clinical care and program integrity with an added focus on whether the current coding structure should be altered as a result. The AAFP urges CMS to include an additional focus on whether the documentation guidelines' emphasis on documentation requirements has had a negative impact on the potential of electronic health records to support clinical decision-making and patient-centeredness. The documentation guidelines that accompany the current code descriptions initially were felt to be necessary because of significant ambiguity in code selection. However, they have proven to be counterproductive for a number of reasons, including negative impacts on the integrity of the clinical record, the potential of electronic health records to support clinical decision-making, and accurate coding. The AAFP previously suggested improvements to the E/M documentation guidelines in a [letter](#) to CMS on May 20, 2015.

Finally, the proposed rule states that "the new codes might be reported based on the resources involved in professional work, instead of the resource costs in terms of clinical staff time." The AAFP observes "professional work" in the context of the RBRVS as a function of time and intensity. There are already add-on codes for E/M time (99354-99359), some of which CMS pays separately for and some of which it does not. Therefore, CMS is actually requesting new add-on codes to describe E/M encounters of greater intensity. The AAFP is not convinced that this can be achieved in a manner that is clinically congruent, administratively simple, amenable to program integrity, and capable of being valued as a basis of payment, given the current knowledge base related to intensity as an element of physician work. The research program suggested above could potentially provide the knowledge and understanding of physician intensity necessary to do what CMS is suggesting.

## *2. Establishing Separate Payment for Collaborative Care*

CMS also seeks comment on how Medicare might accurately account for the resource costs of a more robust interprofessional consultation within the current structure of the Medicare physician fee schedule. For example, CMS requests feedback on appropriate conditions to make separate payment for services

like those described by CPT codes 99446-99449 (interprofessional telephone/internet consultative services). CMS seeks input regarding the parameters of, and resources involved in these collaborations between a specialist and primary care clinician, especially in the context of the structure and valuation of current E/M services. CMS is interested in how these collaborations could be distinguished from the kind of services included in other E/M services, how these services could be described if stakeholders believe the current CPT codes are not adequate, and how these services should be valued. CMS is also interested in whether it should tie those interprofessional consultations to a beneficiary encounter and on developing appropriate beneficiary protections.

Additionally, CMS seeks comment on whether this kind of care might benefit from inclusion in a Center for Medicare & Medicaid Innovation (CMMI) model that would allow Medicare to test its effectiveness with a waiver of beneficiary financial liability and/or variation of payment amounts for the consulting and the primary care clinicians. Finally, CMS seeks feedback on key technology supports needed to support collaboration between specialist and primary care practitioners in support of high quality care management services, on whether it should consider including technology requirements as part of any proposed services, and on how such requirements could be implemented in a way that minimizes burden on providers.

The AAFP encourages CMS to refer to the existing guidelines for CPT codes 99446-99449 (interprofessional telephone/internet consultative services). We also remind the agency that the RUC reviewed these codes in October of 2012 and made recommendations regarding physician work and direct practice expense inputs.

If CMS begins to pay for CPT codes 99446-99449, the AAFP reminds the agency that sometimes interprofessional consultations run both ways. That is, subspecialists sometimes call upon primary care physicians for advice on how to handle certain aspects of their patients' care (e.g. the oncologist who seeks a family physician's advice on how to deal with a cancer patient's diabetes). In such cases, CPT 99446-99449 codes should be available to primary care physicians as well as sub-specialty physicians. Furthermore, in instances where a primary care physician is contacting a subspecialist, it is not clear how the primary care physician would receive compensation for that time. The AAFP urges CMS to address this in the final rule.

The AAFP supports testing the inclusion of these benefits in a CMMI model, similar to what CMS has done with per-patient-per-month (PPPM) care management fees under the Comprehensive Primary Care (CPC) initiative. One way for CMS to test this benefit would be to increase the care management fees under the CPC initiative and allow primary care practices to pay subspecialists for collaborative care as needed under an agreement between the CPC initiative practices and the specialists in their respective medical neighborhoods.

#### *2. a. Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions*

The AAFP position paper on "[Mental Health Care Services by Family Physicians](#)" states, in part, that "the majority of patients with mental health issues will continue to access the health care system through primary care physicians" and describes prevailing payment structures as "an impediment to the family physician's ability to maintain continuity of care," resulting in greater overall health care costs. Thus, there is a strong desire on the part of family physicians to work with psychiatrists and other mental health

professionals on behalf of their patients with mental health issues, and the collaborative care model referenced by CMS is an excellent example. The AAFP strongly supports CMS's intent to operationalize coverage and payment for collaborative care models for beneficiaries with common behavioral health conditions, and we are in conversation with the American Psychiatric Association to help inform CMS's thinking in this regard.

### *3. a. Reducing Administrative Burden for CCM and TCM Services*

CMS solicits comments on ways to further improve beneficiary access to transitional care management (TCM, 99495 and 99496) and chronic care management (CCM, 99490) services while balancing practitioner burdens associated with providing these services.

Though the AAFP understands that only Congress has the authority to address the beneficiary cost-sharing concerns associated with the CCM services, the AAFP nevertheless considers this the prominent problem with the CCM code. Thus, we call on CMS to work with Congress to eliminate beneficiary cost-sharing for the CCM service code. Medicare currently covers a range of preventive services without cost sharing, including mammography, Pap smears, screening for prostate cancer and colorectal cancer, as well as the Medicare annual wellness visit. However, CCM services do not fall under the Medicare preventive services umbrella, even though management also serves to prevent chronic conditions from worsening. Under the CCM code, the beneficiary is responsible for coinsurance of about \$8 once he or she has met the annual Part B deductible, regardless of whether the patient sees the doctor in a separate face-to-face encounter. In the experience of AAFP members, for Medicare patients who lack supplemental coverage, this has led to beneficiary confusion and it creates a particular difficulty in collecting the beneficiary's payment. Given the immensely high value of this service, the AAFP believes that chronic-care management should be available without beneficiary cost sharing.

Though the AAFP encourages its members to incorporate electronic health record technology into their practices, the AAFP nevertheless is concerned that the CCM code's required use of electronic health record technology certified to at least 2014 and the required use of an electronic care plan create a barrier for medical practices to use this code. The AAFP strongly urges CMS to reconsider phasing in these requirements.

Another concern for practices when using the TCM and CCM codes is identifying which patient is eligible. Since not all public and private payers recognize these codes, the AAFP encourages CMS to work with all payers including Medicaid managed care contractors to ensure that patients enrolled in these programs also benefit from and receive these important care coordination services.

As CMS and practices gain experience with these codes, the AAFP urges CMS to reduce unneeded documentation requirements in the spirit of administrative simplification. For instance, we know of at least one practice which was required to refund CCM payments by a Medicare Advantage plan because their patient agreement did not include certain key words or phrases. If CMS and its contractors are going to be this picky about the exact words that are used in the consent form, then CMS should at a minimum generate a consent form that has the required exact words.

It would also be very helpful if CMS made some effort to explain to beneficiaries what the program involves. We have seen little if any beneficiary education on the part of CMS related to CCM. Instead, CMS

has left it to physicians and their practices to provide the necessary beneficiary education. CMS claims that it wants to be a “partner” in the care of Medicare beneficiaries. A partnership implies effort on both parties. We and our members have yet to see any effort on the part of CMS or its contractors when it comes to beneficiary education related to CCM.

Furthermore, the AAFP is aware of ongoing confusion as to whether CCM can be billed for patients in a nursing facility setting. In its frequently asked questions (FAQs) on CCM, CMS states:

As we discussed in the CY 2014 PFS final rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, CPT 99490 cannot be billed to the PFS for patients who reside in a facility (that receives payment from Medicare for care of that beneficiary, see 78 FR 74423) regardless of the location of the billing practitioner, because the payment made to the facility under other payment systems includes care management and coordination. For example, CPT code 99490 cannot be billed to the PFS for services provided to SNF inpatients or hospital inpatients, because the facility is being paid for extensive care planning and care coordination services.

CMS goes on to state, “However, CPT 99490 can only be billed for CCM services furnished to a patient who is not a hospital or SNF inpatient and does not reside in a facility that receives payment from Medicare for that beneficiary.”

This language implies that CCM services can be furnished to and billed for patients in a nursing facility (place of service (POS) 32). However, the FAQs and other CCM guidance on CCM are not clear on this point, leading some family physicians to refrain from providing CCM services to nursing facility patients. We urge CMS to specify that CCM services can be furnished to patients in nursing facilities (POS 32) and can be billed by the physician. CMS might improve beneficiary access to CCM if it further clarified this point.

### *3. b. Payment for CPT Codes Related to CCM Services*

CMS seeks information regarding the circumstances under which the CCM service is furnished. This information includes the clinical status of the beneficiaries receiving the service and the resources involved in furnishing the service, such as the number of documented non-face-to-face minutes furnished by clinical staff in the months the code is reported. CMS is interested in examining such information in order to identify the range of minutes furnished over those months as well as the distribution of the number of minutes within the total volume of services. CMS also seeks objective data regarding the resource costs associated with furnishing the services described by this code. As CMS reviews such information, it will consider any changes in payment and coding that may be warranted in the coming years, including the possibility of establishing separate payment amounts and making Medicare payment for the related CPT codes, such as the complex care coordination codes, CPT codes 99487 and 99489.

Since the CCM service was just recognized by Medicare in 2015, the AAFP does not yet have any data to offer CMS. However, we want the agency to be aware of an AAFP study on the cost and value associated with care management that should be completed next spring. The AAFP looks forward to reviewing this study and will offer it to CMS for the agency’s consideration.

Additionally, CMS should note that the AAFP maintains a National Research Network (NRN) for practice-base research. We would be happy to connect CMS with our National Research Network, since the information that CMS is seeking might make an interesting NRN study.

As CMS contemplates future coding and payment changes related to CCM services, the AAFP continues to urge CMS to:

- Move quickly and create a risk-adjusted, per-patient per-month (PPPM) care management fee approach, similar to the CPC initiative, and then phase out this initial and proposed fee-for-service approach;
- Recognize and pay the other CPT codes, 99487 and 99490;
- Create an add-on code for 99490, which is open-ended at 20 minutes or more.
  - Failing that, CMS should include more than 20 minutes of clinical staff time in the direct PE inputs for the code. For instance, when the RUC reviewed the code, the committee arrived at a recommendation of 60 minutes of registered nurse time as a direct PE input for this service, recognizing that the typical amount of clinical labor time involved would be greater than the minimum that is described by the code. In this instance, the AAFP urges CMS to follow the RUC recommendation of 60 minutes of clinical labor time as a direct PE input, even if CMS insists on having just one code to cover 20 minutes or more of CCM per month based on clinical staff time.

Another way to improve payment accuracy for high-quality primary care would be to address the concerns the AAFP and others raised in an April 30, 2015, [letter](#) to CMS that expressed concern over the misuse of the Medicare Annual Wellness Visit (AWV) by commercial entities. The AAFP continues to believe that the AWV encourages Medicare beneficiaries to engage with their primary care physician or other usual source of care on an annual basis for prevention and early detection of illness, and we are concerned that there are commercial entities that are subverting that benefit and may be misleading patients. We respectfully reiterate our request that CMS investigate and address this issue.

#### II.F. Target for Relative Value Adjustments for Misvalued Services

The *Protecting Access to Medicare Act (PAMA)* of 2014, as modified by the *Achieving a Better Life Experience Act (ABLE)* of 2014, establish targets for net reductions in fee schedule expenditures associated with misvalued services for 2016, 2017, and 2018. The targets are 1.0 percent, 0.5 percent, and 0.5 percent, respectively. If associated net reductions meet or exceed the target, they are redistributed within the fee schedule in accordance with normal budget neutrality rules. Otherwise, the difference between the net reductions and target is essentially removed from the fee schedule via an adjustment to the conversion factor. In the 2016 proposed rule, CMS puts forward a methodology to implement these statutory provisions.

##### *1. Distinguishing “Misvalued Code” Adjustments from Other RVU Adjustments*

CMS proposes to calculate the reduction in expenditures as a result of adjustments to RVUs for misvalued codes by using the estimated pool of all services with revised input values. CMS suggests this method would limit the pool of RVU adjustments used to calculate the net reduction in expenditures to those for the services for which individual, comprehensive review or broader proposed adjustments have resulted in

changes to service-level inputs of work RVUs, direct PE inputs, or MP RVUs, as well as services directly affected by changes to coding for related services.

After considering the options and limitations CMS outlines in the proposed rule, the AAFP concurs that this approach is likely the best alternative short of including all changes in RVUs for a year in calculating the estimated net reduction, which CMS considered and then dismissed as essentially inconsistent with the intent of the law. However, the AAFP also calls on CMS to hold harmless primary care and E/M services in this process, since these services are not over-valued but rather under-valued.

CMS also proposes to exclude code-level input changes for 2015 interim final values from the calculation of the 2016 misvalued code target since the misvalued change occurred over multiple years and includes years not applicable to the misvalued code target provision. While the AAFP understands CMS's reasons for proposing to do this, we nevertheless disagree with this approach, because it essentially means that organized medicine does not get credit for any net decreases associated with those codes. Heretofore, CMS has spread those changes over three years rather than two. In essence, physicians are being penalized since the previous CMS process for handling RVU changes through interim final values is outside the control of physicians. The AAFP therefore urges CMS to consider including 2015 interim final values in the calculation of the 2016 misvalued code target even though the misvalued change occurred over multiple years.

#### *2. Calculating "Net Reduction"*

CMS proposes to net the increases and decreases in values for services, including those for which there are code revisions, in calculating the estimated net reduction in expenditures as a result of adjustments to RVUs for misvalued codes. The AAFP finds that proposal consistent with a plain reading of the statute.

#### *3. Measuring the Adjustments*

CMS proposes to compare the total RVUs (by volume) for the relevant set of codes in the current year to the update year, and divide that result by the total RVUs (by volume) for the current year. CMS seeks comment on whether comparing the update year's work RVUs, direct PE RVUs, indirect PE RVUs, and MP RVUs for the relevant set of codes (by volume) prior to the application of any scaling factors or adjustments to those of the current year would be a preferable methodology for determining the estimated net reduction.

The AAFP believes that CMS in essence is proposing a less precise yet easier to understand formula as an alternative to one that is more precise and harder to replicate and understand. Since CMS finds that both approaches generally resulted in similar estimated net reductions, the AAFP believes the simpler and more understandable approach is preferable.

#### *4. Estimating the Target for 2016*

CMS estimates that the identified net reduction in expenditures is at approximately 0.25 percent. Since the target is 1.00 percent, that means the 0.75 percent difference will need to come from the conversion factor. Doing so would unfortunately more than negate the 0.5 percent increase otherwise promised physicians under MACRA. The AAFP encourages CMS to help further mitigate this result by including 2015 interim final values in the calculation of the 2016 misvalued code target.

## II.G. Phase-in of Significant RVU Reductions

The *Protecting Access to Medicare Act (PAMA)* of 2014, as modified by the *Achieving a Better Life Experience (ABLE) Act* of 2014 requires for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased-in over a 2-year period. CMS makes a series of proposals to implement this change in the law.

### *1. Identifying Services That Are Not New or Revised Codes*

CMS proposes to apply the phase-in to all services that are described by the same, unrevised code in both the current and update year, and to exclude codes that describe different services in the current and update year. This approach would exclude services described by new codes or existing codes for which the descriptors were altered substantially for the update year to change the services that are reported using the code. CMS also would exclude as new and revised codes those codes that describe a different set of services in the update year when compared to the current year by virtue of changes in other, related codes, or codes that are part of a family with significant coding revisions, which would help to maintain appropriate rank order within the family of codes. CMS would also exclude from the phase-in as new and revised codes those with changes to the global period, since the code in the current year would not describe the same units of service as the code in the update year.

The AAFP supports the proposed methodology and appreciates that CMS outlines a fairly broad definition of “new or revised.”

### *2. Estimating the 20 Percent Threshold*

CMS proposes to estimate total RVUs for a service prior to the budget-neutrality redistributions that result from implementing phase-in values. The AAFP concurs with this approach for reasons that CMS provides in the proposed rule.

### *3. RVUs in the First Year of the Phase-In*

CMS proposes to consider a 19-percent reduction as the maximum 1-year reduction and to phase-in any remaining reduction greater than 19 percent in the second year of the phase-in. CMS believes that this approach is more equitable for codes with significant reductions that are less than 20 percent. The alternative would be to phase in the reduction equally over both years.

While the AAFP understands CMS’s rationale for the proposal, the reality is that, with or without a phase-in, codes will change in value by different percentages from one year to the next. All CMS’s proposal would do is to guarantee that codes subject to the phase-in will change in value differently during the first year as compared to the second year. As CMS notes, for most codes, that will mean a larger decrease the first year than the second year. If a code was to drop in payment by 20 percent or more, it makes sense that the decrease should be spread evenly over the two year transition rather than forcing providers of the service to suffer the bulk of it in the first year. To be fair, the AAFP believes CMS should spread the transition evenly over both years, as has been the case with most recent RVU transitions. As CMS notes and the AAFP agrees, this is also the more intuitive approach.

#### *4. Applicable Adjustments to RVUs*

Noting that total RVUs for a code vary by site of service (facility vs. non-facility) and professional component vs. technical component (where applicable), CMS proposes to estimate whether a particular code meets the 20-percent threshold for change in total RVUs by taking into account the total RVUs that apply to a particular setting or to a particular component. Therefore, if the change in total facility RVUs for a code met the threshold, then that change would be phased in over 2 years, even if the change for the total non-facility RVUs for the same code would not be phased in over 2 years. Similarly, if the change in the total RVUs for the technical component of a service meets the 20-percent threshold, then that change would be phased in over 2 years, even if the change for the professional component did not meet the threshold. Since variation of PE RVUs is the only constant across all individual codes, CMS is proposing to apply all adjustments for the phase-in to the PE RVUs to codes with site of service differentials and codes with professional and technical components.

The AAFP understands and supports CMS's proposals in this regard. However, we request CMS to confirm that it would apply all adjustments for the phase-in to the PE RVUs only in situations in which just one site of service or just one component is subject to the phase-in. That is, if both sites of service or both components of a code were subject to the phase-in, it is our understanding that any adjustments would be applied to the work and malpractice RVUs, too.

#### II.I. Valuation of Specific Codes

In this section, CMS proposes to pay for ACP services in 2016. The AAFP submitted our formal comments on this section in a July 23, 2015, [letter](#) that both congratulated CMS and outlined our full support for ACP services.

Apart from ACP services, most of the specific codes are not relevant to family medicine, with a few exceptions:

- In Table 12, CMS notes that it accepted without refinement the direct PE input recommendations for code 692XX (placeholder code #), which represents a new (2016) CPT code for removal of impacted ear wax. The AAFP co-presented those inputs to the RUC with the American Academy of Pediatrics, and we affirm CMS's proposal to accept the RUC's recommendations without refinement.
- In Table 13, CMS proposes to refine the direct PE inputs for a series of laceration repair codes, 12005-12007 and 12013-12016. In each case, CMS proposes to increase the equipment time, eliminate the staff time for discharge day management in the facility setting, and decrease the staff time for checking dressings in the non-facility setting to 3 minutes, which CMS claims is the standard for this function. The AAFP participated in the last RUC survey of these codes with the American College of Emergency Physicians. Since family physicians commonly perform these services, we reviewed the proposed refinements, and we find them acceptable with one exception. CMS proposes a reduction in time to check dressings, etc. The AAFP does not believe there is a standard for this function, so we question where CMS obtained 3 minutes as a standard for this function. While the AAFP acknowledges inconsistencies in the time for this function (e.g., 7 minutes for 12005 vs. 5 minutes for 12016 which involves similar repair lengths) which may merit RUC review, the AAFP does not believe an arbitrary cut across the board to 3 minutes is warranted absent an identified standard in this regard.

The AAFP also noted several codes for which CMS is proposing to reduce the work RVUs commensurate with decreases in intraservice time, total time, and/or post-operative visits, despite RUC recommendations to maintain or increase the work RVUs. The AAFP agrees with CMS in making these changes. For instance, CMS notes that a RUC survey of code 46500 (Injection of sclerosing solution, hemorrhoids) showed a significant decrease in the reported intraservice and total work times. After reviewing the survey responses, the RUC recommended that CMS should maintain the current work RVU of 1.69 in spite of these drops in intraservice and total times. CMS proposes to instead reduce the work RVU to 1.42, which reduces the work RVU by the same ratio as the reduction in total time. This is just one of many such examples, and the AAFP supports CMS in efforts to identify and address such incongruities. It is routine to encounter recommended decreases in physician time and/or post-procedure visits combined with RUC recommendations to maintain or increase the work RVUs. The AAFP agrees with CMS that when physician time decreases, physician work should decrease comparatively, absent a compelling argument that the intensity of the service has increased sufficiently to offset the decrease in physician time.

#### II.J. Medicare Telehealth Services

CMS proposes to add CPT codes 99356-99357 (Prolonged services in the inpatient or observation setting) and 90963-90966 (ESRD related services for home dialysis) to the list of Medicare telehealth services. Codes 99356-99357 would only be reported with subsequent hospital visits or subsequent nursing facility care codes under telehealth, and CMS has limits of one subsequent hospital visit every three days, and one subsequent nursing facility visit every thirty days, that would continue to apply when the services are furnished as telehealth services.

The AAFP supports the inclusion of CPT codes 99356-99357 on the telehealth list. However, the AAFP's policy on [Telemedicine, Licensure and Payment](#) states, in part, "Payment should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be the primary consideration; the critical test is whether the service is medically reasonable and necessary. Care provided via telemedicine should be paid as other physician services." On this basis, the AAFP questions the need for CMS to establish a limit on the frequency with which these services can be provided since there is no such limit when they are provided in-person.

On similar grounds, the AAFP also questions CMS's proposal not to include critical care codes, 99291 and 99292. According to CMS, they have previously considered these codes and declined to include them on the telehealth list because of the acuity of the patients. They also note that they had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care. CMS noted that there was as a study entitled, "Impact of an Intensive Care Unit Telemedicine Program on Patient Outcomes in an Integrated Health Care System," published in the July 2014 *JAMA Internal Medicine*, which found no evidence that the implementation of intensive care unit (ICU) telemedicine significantly reduced mortality rates or hospital length of stay. Consequently, CMS does not believe that the evidence demonstrates a clinical benefit to patients.

The AAFP believes CMS is applying a comparative effectiveness standard to coverage of telehealth services that it applies nowhere else in its coverage and payment for physician services. The AAFP

wonders why must ICU telemedicine demonstrate significantly reduced mortality rates or hospital length of stay to earn Medicare coverage? CMS covers new codes and procedures routinely without any evidence that they significantly reduce mortality rates or hospital length of stay. In accordance with the AAFP's policy, CMS should only consider whether the proposed telehealth services are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. If so, then Medicare should include the service on the list and pay for it. Anything else would be use of a double standard to determine coverage and payment under the Medicare physician fee schedule.

## II.K. Incident-to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements

### *2. Billing Physician as the Supervising Physician*

CMS proposes to clarify that the physician or other practitioner who bills for incident-to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident-to services. CMS also proposes to remove the last sentence from § 410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident-to service is based. As amended, § 410.26(b)(5) would read: "Services and supplies must be furnished under the direct supervision of the billing physician (or other billing practitioner) who is enrolled under Medicare Part B at the time the services are furnished. Services and supplies furnished incident to transitional care management and chronic care management services can be furnished under the general supervision of the physician (or other practitioner) when these services or supplies are provided by clinical staff."

The AAFP reviewed these clarifications and strongly supports these changes. They will allow small primary care practices to continue providing high quality and coordinated care.

### *3. Auxiliary Personnel Who Have Been Excluded or Revoked from Medicare*

CMS proposes to explicitly prohibit auxiliary personnel from providing incident-to services if they either have been excluded from Medicare, Medicaid, and all other federally funded health care programs by the Office of Inspector General or have had their enrollment revoked for any reason. The AAFP supports this change; as CMS noted, such individuals are technically prohibited from providing services to Medicare beneficiaries already.

### *4. Compliance and Oversight*

CMS invites input on approaches to improve the agency's ability to ensure that incident-to services are provided to beneficiaries by qualified individuals in a manner consistent with Medicare statute and regulations. CMS invites commenters to consider the options it will consider, including:

- Creating new categories of enrollment;
- Implementing a mechanism for registration short of full enrollment;
- Requiring the use of claim elements such as modifiers to identify the types of individuals providing services; and
- Relying on post-payment audits, investigations and recoupments by CMS contractors.

We understand that CMS has good intentions with respect to these options. However, the road to bad policy also is paved with good intentions. The AAFP considers these options to be bad ideas, with the possible exception of post-payment audits.

Regarding enrollment or registration, our concerns stem from prior experience with the Medicare enrollment process for physicians, including the Provider Enrollment, Chain, and Ownership System (PECOS), a notoriously cumbersome, time-consuming, and challenging process for providers and physicians. Medicare contractors can barely handle the current enrollment workload without being required to process enrollments for all auxiliary personnel employed by physicians who provide incident-to service. Whether the process is termed “registration” or “enrollment,” it means increased paperwork for physician practices as well as increased workload and oversight for Medicare and its contractors.

Regarding use of modifiers on claims to identify the types of individuals providing the service, the AAFP does not believe it is necessary or prudent. (We note that our suggestion to do so in the context of more appropriately valuing global surgical services would be a time-limited exception done for a specific data gathering purpose and limited to a sample of physicians as required by *MACRA*.) Adding this information will not alter the payment allowance or patient’s coverage; it only allows CMS contractors to collect yet another piece of information on a claims form. The cost to practices to capture and record this information on each claim would be considerable.

Since there is no assertion in the preamble (e.g., by way of citing a Government Accountability Office or Office of Inspector General study) that incident to services are being abused, the AAFP wonders what concerns CMS is attempting to address. The multiple, existing fraud and abuse strategies in place by CMS and its contractors, including targeted (not random) post-payment audits and recoupments by CMS contractors, should be utilized fully. The AAFP strongly urges that CMS avoid placing new claims-based reporting burdens on physicians, since they figuratively and literally put their names on the line when billing incident to services to Medicare. CMS should avoid creating new hassles that burden the vast majority of practices who are billing appropriately for the sake of a few potential abusers.

### III.B. Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes to provide an additional payment for the costs of CCM services that are not already captured in RHC and FQHC payments, beginning on January 1, 2016. All aspects of their proposal mirror the current requirements and aspects of CCM payment under the physician fee schedule for practices that are not RHCs and FQHCs.

Since the AAFP previously encouraged CMS to pay RHCs and FQHCs for CCM services, we fully support CMS making this proposal now. The AAFP will continue to educate our members, including those in RHCs and FQHCs, about new services such as CCM but also the TCM and ACP services.

The AAFP requests CMS clarify one aspect in the final rule. On page 41796, CMS alternately refers to “a CCM 30-day period” and “only one CCM payment can be paid per beneficiary per month.” Under the Medicare physician fee schedule and per CPT, CCM as defined by code 99490 is a calendar month

service. The AAFP encourages CMS to reference it as such when the final rule is published and avoid any references to CCM as a 30-day period.

### III.G. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The AAFP continues to have significant concerns about the disproportional burden primary care physicians will face in 2017 when trying to comply with Section 218 of the *Protecting Access to Medicare Act (PAMA)*, which requires physicians ordering certain imaging services (magnetic resonance, computed tomography, nuclear medicine, and positron emission tomography imaging services) for Medicare beneficiaries to consult appropriate use criteria applicable to the imaging modality. We appreciate that CMS fully recognizes that appropriate use criteria, “crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite vast.”

The AAFP strongly recommends that CMS phase-in an initial focus on a limited number of clinical conditions and related AUC. CMS should begin this process with health systems and large group practices, and, over time, expand it into smaller practice size settings. We recommend this since large entities have the infrastructure to support the required consultations and reporting procedures.

Many primary care physicians already find their current EHRs systems to be cumbersome and impeding patient care. The AAFP is concerned that EHRs will not be able to address the workflow problems for the ordering physician when consulting and documenting that appropriate-use criteria were accessed. We have seen evidence of this obstacle in implementations of Meaningful Use requirements.

In a July 19, 2015, [letter](#), we asked the Office of the National Coordinator (ONC) to consider carefully how “appropriate use criteria” can be workable in a practice’s EHR system. Conceptually, we support voluntary adherence to appropriate-use criteria as a mechanism to promote evidence-based medicine developed by national professional medical specialty societies or provider-led entities. We believe CMS and ONC should facilitate compliance by establishing interoperability standards and requiring all EHRs to adhere to the appropriate-use criteria specified by CMS. In summary, primary care physicians cannot comply unless these standards of interoperability have first been implemented and required of all vendors.

In this proposed rule, CMS outlines two different approaches for the implementation of appropriate-use criteria. One is a broad approach, and the other is more focused. The AAFP encourages CMS to pursue the broad approach for reasons that CMS outlines. The more focused approach would be significantly more burdensome for practices to follow. But again, these appropriate-use criteria should not be implemented in any fashion until the issues of EHR workflow and interoperability issues have been addressed.

Regarding the development of provider-led appropriate-use criteria, the AAFP urges CMS to require primary care physicians as a member of the multidisciplinary team in addition to an expert on the clinical topic and an expert in the imaging studies related to the criterion. Since primary care physicians frequently order these imaging services and since they will be burdened by the required use of this tool, primary care physicians should be involved with all aspects of developing appropriate-use criteria.

While the AAFP supports requiring provider-led entities that develop appropriate-use criteria to have a publicly transparent process for identifying and disclosing potential conflicts of interest, the AAFP is concerned that disclosure is not enough. Each member of these multidisciplinary teams must not have significant conflicts of interest, and there should be a process to exclude those who do.

In multiple areas in this section, CMS refers to reviewing evidence-based medicine "to the extent feasible." The AAFP encourages CMS to prioritize the list of clinical areas and only include those with a strong evidence base. While consensus opinion is sometimes accepted as "evidence," physicians and patients should ultimately not be held to a standard that does not have real evidence behind it.

### III.H. Physician Compare Website

The AAFP is supportive of the Physician Compare concept but has several concerns regarding the complexity and accuracy of the information and its usefulness to consumers. It is increasingly important for CMS to address these concerns, because *MACRA* expands the use of the Physician Compare website.

While CMS has mechanisms in place to ensure the data is valid, reliable, and correctly attributed, errors still persist. Because of this, the AAFP urges CMS to extend the current preview period from 30 to 90 days at a minimum. This will give the physician sufficient time to review, validate, and appeal, if needed, before public reporting of his or her data. If information is under review, it should not be publicly reported on the website until the issues are resolved. Additionally, we suggest that only group-level data be reported on Physician Compare until this issue is resolved completely. When making decisions regarding their health care, consumers should be able to view accurate performance data.

While the information needs to be simplistic for the consumer to make informed medical decisions, many of the included measures and their methodologies are complex and multi-faceted. A star rating system that simplifies performance information could result in inappropriate distinctions of quality. Similarly, a green checkmark for providers receiving an upward adjustment under the value-based payment modifier oversimplifies what success truly looks like in the program.

The AAFP also is concerned about the timeliness of the feedback reports given to physicians and group practices. These reports are not available until approximately six to nine months after the close of the reporting period, giving no opportunity for a practice to improve performance until well into the next reporting period. The AAFP urges CMS to provide feedback to physicians much sooner so improvement can take place before implementing the Achievable Benchmark of Care (ABC) methodology and public posting on Physician Compare. The AAFP is pleased that CMS decided against the weighted-average benchmarking option. Since benchmarking will be a new feature of the Physician Compare website, the AAFP strongly urges CMS to consider phasing in the ABC methodology by including only a small set of well-known and tested measures. The implementation of the ABC methodology should take place after the feedback reports are made available in a timely fashion, so physicians have the opportunity to improve. Once the standard is set that feedback reports are made available soon after the reporting year closes, the AAFP proposes implementing the ABC methodology as a pilot to accurately determine if it is the most appropriate approach to evaluating physician performance. Once it has been evaluated and deemed appropriate (by both CMS and

stakeholders) to set the standard of care within the Physician Compare website, it then could be fully implemented.

Additionally, the AAFP strongly urges CMS to incorporate the [Core Quality Measures Collaborative's](#) aligned measure sets (when finalized) into Physician Compare.

### III.I. Physician Payment, Efficiency, and Quality Improvements

#### *Physician Quality Reporting System (PQRS)*

CMS proposes several modifications to the PQRS. As AAFP understands this section, CMS proposes to align 2018 payment adjustment (based on 2016 performance) policies with what CMS currently requires for the 2017 payment adjustment (based on 2015 performance). The one exception is for groups of 25 or more eligible professionals who register to participate in the PQRS GPRO and select the GPRO web interface as the reporting mechanism; CMS proposes that they will have to do the CAHPS survey.

The AAFP strongly opposes the premature expansion of Clinician and Group-CAHPS to 25+ eligible professionals reporting via GPRO. The mandate to use a CAHPS certified vendor comes with great expense and is resource intensive, especially for smaller practices. The AAFP asks that CMS bear the cost of the administration of the Clinician and Group-CAHPS by a CMS certified vendor for groups of 25 or less providers. If not, other instruments for assessing patient experience should be considered due to cost and the burden of implementation. Furthermore, practices should not be penalized for factors outside of their control such as lack of patient engagement for completing the survey. We would note that CMS, as part of the Core Quality Measures Collaborative effort with the AHIP and others, has suggested that the CAHPS survey be provided free to physician offices and their patients through an online process. The AAFP is very supportive of this effort for all practices and especially for those with 25 or less physicians or other providers.

The AAFP again urges CMS to incorporate the [Core Quality Measures Collaborative's](#) aligned measure sets (when finalized) into PQRS as a future reporting option.

The AAFP urges CMS to reconsider the proposed measures included that are not recommended by the Measures Application Partnership (MAP). The MAP is comprised of multi-stakeholder experts that have deep knowledge and expertise regarding performance measurement. Their recommendations should be followed, and CMS should not consider measures for inclusion in PQRS until there is consensus from the MAP. While many of the measures may be filling a clinical gap, the feasibility of implementation may be lacking. Choosing a measure in order to fill a "clinical gap" when there is no feasible way to capture data is counter-intuitive and ultimately does not serve its purpose of assessing quality. This also seems contrary to current CMS efforts to create and harmonize a parsimonious set of clinical performance measures across all payers.

The AAFP urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic determinates such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not

adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified.

CMS seeks comments regarding the facilitators and obstacles providers and vendors may face in collecting and reporting patient attributes such as race, ethnicity, sex, primary language, and disability status. Additionally, CMS seeks comments on preference for a phased-in approach, perhaps starting with a subset of measures versus a requirement across all possible measures and mechanisms with an adequate timeline for implementation. The AAFP prefers a phased-in approach that accounts for not only the number of measures and reporting mechanisms involved but also practices size. For instance, as with the value modifier, CMS might start with groups of 100 or more, then expand to groups of either 10 or 25 or more, and hit solo/small groups last.

The AAFP supports the proposal to allow more time for QCDR to self-nominate.

*Request for Input on the Provisions Included in the MACRA Merit-Based Incentive Payment System (MIPS)*

Section 101(c) of the *MACRA* calls for the creation of the MIPS beginning with payments for items and services furnished on or after January 1, 2019. Components of the MIPS include the adjustment factor/scoring, composite performance score, and performance threshold. CMS will develop the MIPS through future rule-making but, at this point, requests feedback on the low-volume threshold and clinical practice improvement activities CMS should examine as part of the MIPS.

*Low-volume Threshold*

The AAFP recommends CMS set a total minimum number of individuals enrolled under Medicare Part B rather than impose a percentage of a practice's total patient panel. Rather than suggest the appropriate minimum number at this point, we urge CMS to seek input on this number through future requests for information. The AAFP is inclined to believe that percentage of patient volume attributable to Medicare is not the best marker of patient volume; an absolute number of Medicare patients treated is clearer.

As CMS contemplates minimum thresholds, we urge the agency to examine minimum thresholds in other programs and the effectiveness of those thresholds. For instance, the minimum threshold under the Comprehensive Primary Care Initiative is 150 patients, and under PQRS, it is 20 patients per measure. In this context, the AAFP notes that many eligible professionals do not participate in PQRS. CMS should intensely examine the barriers to PQRS participation facing many specialties and apply what it learns to the MIPS and APMs, which will be more intensive merit-based programs than the PQRS is.

The AAFP also urges CMS to consider a tiered approach with three levels for the MIPS. At the lowest level, CMS could consider setting an absolute minimum number of patients required, below which MIPS participation would not be allowed. At the top level, above a certain number of patients, MIPS participation would be automatic if the physician or practice is not in an APM. In between those two tiers would be a tier in which a physician or practice could opt in to MIPS participation.

<http://www.aafp.org/dam/AAFP/documents/advocacy/prevention/tobacco/LT-FDA-TobaccoMarketing-082515.pdf>*Clinical Practice-Improvement Activities*

The AAFP believes that CMS could consider a wide range of services that could be considered as clinical practice improvement activities, including:

- Open access scheduling;
- 24/7 patient access to the care team;
- Participation in a QCDR recognized by CMS under PQRS;
- Successful provision of chronic care management (CCM) services;
- Use of remote patient monitoring;
- Ability to provide e-visits or other forms of telehealth services;
- Maintenance of certification Part IV- Performance in Practice as required by the American Board of Family Medicine;
- Patient portal usage;
- Extended clinic hours;
- Use of risk-stratified care management to identify the intensity of services to high risk patients;
- Proactive outreach and pre-visit planning for chronic and preventative care;
- Transitional care management (e.g., emergency department and hospitalization follow-ups);
- Shared decision making;
- Use of a patient advisory council;
- Motivational interviewing;
- Group visits
- Health coaching;
- Use of appropriate screening tools for patient population; and
- Conducting Medicare annual wellness visits to include patient safety.

We do not expect that a practice would or should need to do all of these things. Rather, they represent a menu of possibilities, some portion of which might satisfy the *MACRA* requirements.

#### Alternative Payment Models

Section 101(e) of *MACRA* introduces a framework for promoting and developing APMs and for providing incentive payments for eligible professionals who participate in APMs. While CMS will develop the details surrounding APMs over several years, family physicians and other primary care physicians and the patients they treat should greatly benefit from APMs that emphasize value and population health over volume and fee-for-service health care. Family medicine should benefit from APMs because CMS's goals for APMs align with the value that primary care physicians bring to the health system. Since the goals set by CMS are consonant with the skill set, experience, and mission of family medicine, CMS should put family physicians and other primary care physicians in central, important roles when developing APMs.

One of the biggest barriers to participation is the lack of APM models available. Many primary care practices will not be able to participate effectively in an APM unless resources are provided to the practice to overcome significant cost and workflow barriers against practice transformation. Key among the barriers is the lack of contract negotiation experience, limited capital for information technology systems, and insufficient access to price information on certain services. In addition, if payers want primary care physicians to accept responsibility for the total cost of care, they must provide the primary

care physicians with timely and accurate data on the cost and quality of all physicians, hospitals and outpatient care facilities in their community or service area.

Another barrier APMs must overcome, as well as all quality programs, is achieving harmonization of quality and other measures across all payers. Otherwise, primary care practices participating in APMs could experience an increase in administrative burdens.

The AAFP believes APMs will work best and will more likely succeed if physicians and their practices receive considerable support, guidance, and tools to participate in them. Physicians need resources to optimize the quality of their work, including clinical and administrative work, to succeed in APMs. Asking physicians to learn, understand, execute, and then review their care delivery and performance under newly created APMs carries the risk of adding administrative work for already overburdened physicians.

Furthermore, when physicians have been reporting increased incidences of burnout, the last thing public and private payers should do is introduce additional work unrelated to patient care. Unless CMS facilitates the transition to APMs by easing physician burdens in other areas, many practices will not be able to make the transition. Providing clear operational details and performance goals of APMs, along with an easy-to-use mechanism to collect, use, and share data, is the only way to improve patients' experience of care and the health of populations while reducing the per-capita cost of health care.

The AAFP believes the key to APMs is the collection, use, and sharing of data. Therefore, the most important tool or resource for physicians is data management, analysis, and reporting. However, many practices would need to make substantial information technology (IT) investments to manage, analyze, and report patient care effectively. Incorporating other performance data related to quality, utilization, and costs into the physician's practice profile would require IT capabilities that most practices EHRs do not currently have. While financial resources are necessary for primary care practices to make these investments and can come from such practices integrating or affiliating with each other and hospitals, payers and plans should also provide an appropriate part of the needed financial investments.

The AAFP believes that physicians moving into APMs will need to formulate a comprehensive strategy that will simultaneously improve population health, preserve or enhance physician satisfaction, and ensure economic viability. Stakeholders from across the spectrum of the health care industry will need to collaborate to ensure success throughout the health care continuum.

#### III.J. Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use Aligned Reporting

CMS proposes several technical changes designed to ensure that providers participating in PQRS and the EHR Incentive Programs under the 2015 Edition possess EHRs that have been certified to report CQMs according to the format that CMS requires for submission. The AAFP continues to be a strong advocate for both interoperability in EHRs and quality measurement within a medical practice.

We also believe it is important to standardize the data needed for quality measurement to be conveyed from practices to external entities. With the complexity of standards and their implementation, it is important that EHRs and other health IT be tested to verify they can support selected standards. The

AAFP is supportive of including quality measurement reporting standards into the certification process for EHRs. The AAFP also continues to support modular certification that would allow eligible professionals to report quality data from either their complete EHR or via a specialized third-party application or service.

### *3. Electronic Health Record (EHR) Incentive Program-Comprehensive Primary Care (CPC) Initiative Aligned Reporting*

The AAFP supports the continued alignment between the CPC initiative and meaningful use electronic submission of clinical quality measures (e-CQM) reporting requirements. Additionally, we support the proposal to expand the aligned reporting option via the CPC group reporting option of those CPC eligible professionals who are in their first year of demonstrating meaningful use. However, the proposed regulation penalizes first year CPC eligible professionals for submitting a full year of e-CQMs data instead of the required 90-day period. CPC practices submitting above and beyond the requirements of meaningful use should not be penalized for doing so. The AAFP urges CMS to permit CPC practices that elect to electronically report through the CPC practice site to successfully attest to meaningful use using one full year as the reporting period.

Finally, the AAFP notes the struggle CPC practices experience to report e-CQMs as outlined in the "First Year Evaluation Report." Even though these practices may have an ONC-certified EHR, practices have found that their vendor is unable to satisfactorily aggregate and report data for the initiative. For this reason, the AAFP strongly urges CMS to be as accommodating as possible for reporting purposes, so practices can satisfactorily demonstrate meaningful use and participate successfully in the CPC initiative.

### III.K. Potential Expansion of the Comprehensive Primary Care (CPC) Initiative

CMS can expand the duration and scope of a model that is expected to either reduce Medicare spending without reducing quality of care or improve the quality of patient care without increasing spending, among other requirements. Consequently, in the proposed rule, CMS seeks feedback on the potential expansion of the CPC initiative. In particular CMS seeks feedback on:

- *Practice readiness:* While we strongly support the expansion of the CPC Initiative as broadly as possible, the AAFP does not believe every practice is ready to take on CPC care delivery functions and achievement of milestones. Physicians need assistance with transforming their clinical practices and pursuing comprehensive quality improvement strategies. Small, independent practices in particular need assistance, since they often lack the resources required to invest in infrastructure to prepare for innovative models. Though EHR adoption is widespread in family medicine, regional and rural pockets persist and are a major barrier against practice readiness.
- *Practice standards and reporting:* The AAFP believes the milestone approach is positive. The AAFP encourages CMS to continue its use. While the AAFP understands the need for ongoing reporting, the burden that such reporting places on the smaller primary care practices is of concern. Because these practices have less staff to draw upon, they have more difficulty reporting on the number of milestones required each quarter. However, the AAFP also is concerned with the ability to report e-CQMs through a practice's certified-EHR. Member feedback is that EHR reporting continues to prove difficult for a variety of reasons. Many

practices report that their EHR does not have the capability to aggregate their CQM numerators, denominators, exclusions, and performance rates at the practice level due to their EHR certification requirements. This situation is of significant concern to the AAFP and should be for CMS as well. While ONC CERT is a requirement for CPC participation, it has proven to be a significant obstacle for one of the most foundational milestones of the program. Since reporting is required to be eligible for shared savings, many practices may not have the opportunity to participate due to lacking the functionality in their EHR. The AAFP urges CMS to consider an exception or another reporting mechanism for practices to fully participate in reporting and qualify for shared savings.

- *Practice groupings:* CMS seeks input as to whether any potential expansion should be limited to existing CPC regions, or include new geographic regions. The AAFP strongly believes CMS should seek to expand the CPC initiative to as many geographic regions and practice sites as possible. Multi-site practices should be included in an expansion of CPC, and they would be able to more rapidly spread the CPC model. Shared savings should be calculated at the practice level to reward practices for their work towards cost savings, CAHPS, and quality measures. Calculating this at the regional level could negatively impact high-performing practices that are located in a low-performing region.
- *Interaction with state primary care transformation initiatives:* The AAFP encourages CMS to collaborate with local and state projects as much as possible. We also encourage CMS to seek out opportunities for collaboration and alignment with the work of the Transforming Clinical Practice Initiative (TCPI) Practice Transformation Networks (PTNs) to help expand the CPC model.
- *Learning activities:* The AAFP believes the “First Year Evaluation Report”, in addition to CPC practices’ feedback, points to the effectiveness of collaborative learning sessions in which physicians and their practice staff have the opportunity to learn from their peers. We appreciate CMS’s efforts in this regard and urge the agency to continue this collaborative process. Learning best practices from high performing practices has been valuable in CPC. The AAFP also supports the regional learning faculty’s continuation of visiting the practices to provide in-person assistance. Practices place high value in this type of assistance.
- *Medicaid, payer, and self-insured employer readiness:* The AAFP is fully supportive of all public, private payers, and managed care plans participating in the expansion of CPC.
- *Quality reporting:* The “First Year Evaluation Report” stated that a significant number of CPC practices in year one could not report their e-CQMs electronically, and the struggle continued in 2014. The inability to report e-CQMs in program year 2014 disqualifies practices from being eligible for shared savings. The AAFP urges CMS to consider an exception or another reporting mechanism for practices to fully participate in reporting and qualify for shared savings.
- *Interaction with the CCM fee:* CMS seeks input on how payment for CCM services might interact with a potential expansion of the CPC initiative. One of the great benefits of the CPC model is the up-front, non-visit care management fee that a practice can utilize without the documentation required by CCM – a much better example of an APM compared to the use of the CCM code. This allows a practice to use the funds to support care management work and to help the practice to better achieve milestones with the additional resources. If the CPC model is to be expanded with new practices, the AAFP urges CMS to sustain the current enhanced payment model to allow newly participating practices to invest in their primary care

transformation efforts. Furthermore, since there currently is no plan for how existing CPC practices will carry on their care management funding beyond year four of the CPC initiative, we strongly urge CMS to clearly state immediately that this payment model will be extended indefinitely, so current participating practices understand that this funding will continue to support the benefits to patients and the substantial changes made to their practices. The AAFP supports moving away from fee-for-service codes like the CCM towards risk-adjusted, per-patient per-month payments.

- *Provision of data feedback to practices:* The AAFP believes that only timely and actionable data allows practices to use real-time information to drive improvements. Many practices currently find accessing the quarterly feedback reports too time-consuming and burdensome. While CMS has made these reports available on the CPC web application, the agency should consider better ways to deliver this information to practices in a more effective manner. Additionally, AAFP members report difficulty understanding the methodologies and information in the reports such that further explanation for practices is needed. The AAFP encourages CMS to continue to use regional learning faculty to educate practices on how to interpret and best use the reports. The AAFP also urges CMS to continue data aggregation efforts, which generate invaluable information for practices because they can focus on a single report, instead of many from each payer. Physicians need education and support to understand the meaning of total cost of care, how it is determined, how they can assess cost of care for their patients, and how they can best act on this information. CMS needs to make cost transparency and quality outcomes for all services available to primary care physicians and their practice teams, so they can make cost-effective decisions without sacrificing quality.

### III.M. Value-Based Payment Modifier and Physician Feedback Program

The value-based payment modifier (VM) provides for differential payments under the physician fee schedule to physicians, groups of physicians, and other eligible professionals based on the quality and cost of care they furnish to Medicare beneficiaries. Under the VM program, performance on quality and cost measures can translate into payment incentives for eligible professionals who provide high-quality, efficient care, while eligible professionals who underperform may be subject to a downward adjustment.

The AAFP opposes the proposed adoption of the Clinician-Group-CAHPS as the single instrument to measure patient experience under the PQRS and value-based modifier programs. The mandate to use a CAHPS-certified vendor comes with great expense and is resource intensive, especially for smaller practices. Yet, mandated use of a CAHPS-certified vendor seems to be the direction of the program. The AAFP asks that CMS bear the cost for the administration of the CG-CAHPS by a CMS-certified vendor for small practices. If not, other instruments for assessing patient experience should be considered to mitigate the cost and the burden of implementation. Furthermore, practices should not be penalized for factors outside of their control such as lack of patient engagement for completing the survey. We reiterate the belief that the CAHPS survey should be provided free to physician offices and their patients through an online process.

The AAFP supports CMS's proposal that creates separate benchmarks for e-CQMs due to the variance when compared to the equivalent measures reported through a different reporting mechanism. A separate e-CQM benchmark will better reflect the measure's specifications.

The AAFP supports CMS's proposal to stratify the cost measure benchmarks, so groups and solo physicians are compared to like groups treating patients with similar profiles. In addition, the AAFP urges CMS to move forward with expanding its risk-adjustment for socioeconomic status methodology into the calculation of the per-capita cost measures and the claims-based outcome measures. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison among physician performance by adjusting for factors outside of their control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified.

In this section, CMS also discusses stratification of cost measure benchmarks by beneficiary risk score. CMS currently uses the hierarchical condition categories' risk-adjustment methodology in the total per capita cost measures for the VM and indicates the intent to continue to explore potential risk adjustment refinements. One option CMS is considering would be to stratify the cost measure benchmarks, so groups and solo practitioners are compared to other groups and individual practitioners treating beneficiaries with similar risk profiles. In this way, within a given grouping (for example, a quartile or decile), there remains an opportunity to gain efficiencies in care and lower costs, while beneficiary severity of illness and practice characteristics may be more fully recognized at a smaller, and likely less heterogeneous, attributed beneficiary level.

The AAFP supports the proposed expansion of the availability of the quality and resources use reports (QRUR) to include non-eligible professionals and the ACO and CPC initiative participants. Additionally, the AAFP applauds CMS's efforts to provide physician cost and quality outcomes more frequently by providing the Mid-Year QRUR. However, the AAFP urges CMS to make more physicians aware of the QRUR and to make QRURs easier to access. Most physicians are unaware of the report's existence, let alone the importance of the information contained within it. Additionally, the tables and calculations contained in the report can be difficult to interpret, let alone act on. The AAFP urges CMS to provide more technical assistance to practices to better understand the quality and cost data and how that data will impact their Medicare payment.

The AAFP appreciates the opportunity to provide these recommendations and comments. For any questions you might have please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aaafp.org](mailto:rbennett@aaafp.org).

Sincerely,



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