



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  

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STRONG MEDICINE FOR AMERICA

July 29, 2009

Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1413-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Ms. Frizzera:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 94,000 physicians and medical students nationwide. Specifically, I am writing to offer our comments on the proposed rule regarding payment policies under the Medicare physician fee schedule and other revisions to Medicare Part B for calendar year 2010. The Centers for Medicare and Medicaid Services (CMS) published the proposed rule in the *Federal Register* on July 13, 2009, and invited comments on various issues in the proposed rule. We are grateful for the recognition of and support for the value of primary care represented by several key policy changes proposed in this rule. Our comments on issues of relevance to family medicine generally follow the order of the issues as presented in the proposed rule.

Resource Based Practice Expense (PE) Relative Value Units (RVUs) – Physician Practice Information Survey

CMS proposes to update the PE per hour data used in its PE RVU methodology. Specifically, CMS proposes, with few exceptions, to use data from the Physician Practice Information Survey (PPIS), rather than continuing to rely on the combination of data from the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) and supplemental survey data supplied by selected specialties.

AAFP strongly supports CMS's proposal to use the PPIS data. The SMS data currently used by CMS is at least 10 years old and represents practice costs from 1995 to 1999, which does not account for the increased costs practices now face. We believe that Medicare should use the most current and accurate data to determine PE payments for all Medicare Part B providers. We note that the Medicare Payment Advisory Commission (MedPAC) has been calling for CMS to update its practice expense data since 2006, and in its June Report to Congress, MedPAC stated that "The data source CMS uses to estimate total practice costs is dated and may not reflect the current practice patterns. Up-to-date and accurate data is needed for all specialties..."

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Another problem with the SMS data is that CMS does not use it across the board. For some specialties, CMS uses supplemental survey data collected at different time periods with different survey instruments. The Balanced Budget Refinement Act of 1999 (BBRA) permitted specialties to submit more current (supplemental data) on PE and CMS accepted such data through 2006. However, many organizations were unable to submit data due to the high costs of doing so or because they believed that doing so in such a segregated fashion was not appropriate. Unfortunately, using PE data from some but not all physicians or healthcare professionals who bill Part B services has caused significant distortions. Further CMS indicated in 2007 that it would not accept any further supplemental data.

The PPIS data was collected at the same time for all specialties using the same survey instrument. The PPIS methodology was consistent with the SMS and supplemental survey methodologies, and virtually all physician specialty societies participated in and supported the PPIS.

The PPIS was a high quality undertaking that used a survey instrument that the American Medical Association (AMA) took great care to design, test and implement and sought input throughout the process from all impacted physician and healthcare professional organizations. The survey process was jointly funded by the 72 organizations whose members participated in the survey at a cost of \$2.4 million. The survey was conducted by external contractors using randomly selected samples from AMA's Physician Masterfile that includes both members and non-members. The project was initiated by Gallup Organization in 2007 and then transitioned to a more experienced physician practice expense survey organization, dmrkynetic, to complete the effort after an initial slow start. CMS has very strict criteria for this type of survey data. All participants met the requirements as outlined. Further, the AMA worked with a CMS contractor, The Lewin Group, to ensure that all data was analyzed consistently and that any inappropriate data (e.g., did not meet criteria, were response outliers, represented responses that were statistically unacceptable, etc.) were excluded. Lewin independently corroborated the results and recommended that CMS utilize the data. CMS showed its confidence in the data by purchasing it from the AMA.

In short, as a contemporaneous, consistently collected, and comprehensive multispecialty survey, the PPIS represents the best currently available data source on physician practice expenses. By using this survey data CMS will now have more accurate information for many more physician and healthcare providers than was represented in the SMS data, which only contained data for 26 physician specialties and no non-physician practitioners. Its use will update all providers at the same time, correcting flaws and unevenly allocated payments associated with the current mix of SMS and supplemental data. For these reasons, AAFP supports CMS's proposal.

#### Resource Based PE RVUs – Equipment Utilization Rate

In the proposed rule, CMS proposes to change the equipment usage assumption in its PE RVU methodology. Specifically, CMS proposes to change from the current 50% usage rate to a 90% usage rate for equipment priced over \$1 million.

AAFP strongly supports CMS's proposal to increase the assumed usage rate for equipment priced at over \$1 million. The proposal is supported by studies previously noted by MedPAC. It also comports with common business sense (i.e., no one would typically invest millions of dollars in equipment that they only planned to use half of the time). Absent empirical data to the contrary, CMS's proposal likely more closely approximates reality than the current 50% assumption for such equipment.

#### Malpractice Relative Value Units (RVUs)

Consistent with the statutory requirement that it review and, if necessary, adjust RVUs no less often than every five years, CMS proposes to update the malpractice RVUs, which CMS last updated in 2005. The proposed methodology largely parallels the methodology used in 2005. The primary difference now is that CMS is using more current data. Also, CMS proposes a change in the way it addresses the malpractice RVUs of the technical component of services. Specifically, CMS proposes to set the technical component malpractice RVUs equal to the difference between global malpractice RVUs and the professional component malpractice RVUs. CMS projects that family physicians will see a 1% increase in their total Medicare allowed charges from the proposed malpractice RVU changes.

We have reviewed the proposed methodology and update to the malpractice RVUs and are generally supportive of the approach that CMS proposes. We appreciate that CMS is using the most current malpractice premium data available, including rate filings from everywhere except Mississippi and Puerto Rico. We also appreciate CMS's attempt to address concerns surrounding the malpractice RVUs of technical component services. The proposed use of medical physicists' premium data (instead of historical charges) as a proxy for the malpractice premiums paid by entities providing technical component services seems like a reasonable approach to begin to address the apparent anomalies in which some technical component services have higher malpractice RVUs than their corresponding professional components. The proposal to set the technical component malpractice RVUs equal to the difference between global malpractice RVUs and the professional component malpractice RVUs also seems reasonable in this regard.

#### Medicare Telehealth Services

In the proposed rule, CMS responds to requests that it has received to add certain services as Medicare telehealth services effective for calendar year 2010. Of all those requests, CMS proposes to add only individual health and behavior assessment and intervention and follow-up inpatient consultations in a skilled nursing facility as Medicare telehealth services effective for calendar year 2010.

In deciding whether or not to add certain services as Medicare telehealth services, CMS first considers whether or not the services are similar to professional consultations, office visits, and office psychiatry services, which are statutorily defined as Medicare telehealth services. If not, CMS then considers whether or not the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face, "hands on" delivery of the same service. In this case, CMS expects

requesters to submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

We continue to believe that CMS's approach to determining whether or not to add certain services as Medicare telehealth services is fundamentally flawed. From our perspective, the technology used to deliver the services should not be the primary consideration in determining whether or not to pay for telehealth services. The critical test is whether the service is medically reasonable and necessary. Medical necessity, not the technology involved, should be the determining factor.

We believe that care provided via telemedicine should be paid as other physician services and can be a win-win-win for Medicare, the patient, and physician. By creating ready access to information, telemedicine can provide rural physicians in particular with current medical information that may not be available in an isolated setting. Regrettably, CMS's approach to decisions on Medicare telehealth services works against such access. Indeed, CMS's approach essentially applies a comparative-effectiveness standard to telehealth services requests that is not applied to any other services of which we are aware for which Medicare pays. We fail to see how CMS can justify this double-standard.

#### Payment for Initial Preventive Physical Examination (i.e., Welcome to Medicare Visit)

Effective January 1, 2010, CMS proposes to increase the work RVUs for this service from 1.34 to 2.30. AAFP supports CMS's proposal to increase the work RVUs for this service. The AAFP has argued, since the service's inception, that this service is undervalued. The increase in work RVUs, equivalent to a level 4, new patient office visit, brings this service more in line with the relative value of other evaluation and management (E/M) services done by family physicians.

#### Consultation Services

Effective January 1, 2010, CMS proposes to eliminate the use of all consultation codes (except for telehealth consultation G-codes) and, in a budget neutral manner, increase the work RVUs for new and established office visits, increase the work RVUs for initial hospital and initial nursing facility visits, and incorporate the increased use of these visits into the PE and malpractice RVU calculations. CMS also proposes to create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions.

CMS currently values consultation services higher than corresponding office and inpatient visit services at the same level. (For example, a mid-level outpatient consultation has 1.88 work RVUs compared to 1.34 or 0.92 work RVUs for a mid-level new or established patient office visit, respectively.) CMS's proposal to eliminate the consultation codes in a budget neutral way will shift that difference in RVUs to office visits and initial hospital and nursing facility visits. According to CMS, this will increase the work RVUs for office visits by approximately 6% and the work RVUs for initial hospital and nursing facility visits by approximately 2%.

CMS believes the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. For instance, CMS notes that, historically, the payment for an inpatient consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, as CMS points out, all medically necessary Medicare services require documentation in some form in a patient's medical record. Additionally, CMS has eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, as long as the identity of the physician who furnished the consultation is evident.

AAFP supports the appropriate valuation of all services paid under the Medicare physician fee schedule. As noted in the proposed rule, the distinction between consultations and other E/M services has become increasingly blurry over time, leading to significant misuse of the consultation codes, which the Office of Inspector General has documented. Thus, because it is impossible to justify the difference in physician work assigned to these services, and because this proposal offers significant reductions in administrative burden and compliance risk to physicians, we support CMS's proposal to eliminate the use of consultation codes and make budget neutral adjustments to shift the difference in RVU's to other E/M services done in the same setting.

#### Potentially Misvalued Codes under the Physician Fee Schedule

##### **Site of Service Anomalies**

CMS proposes to recalculate and change the work RVUs for codes for which the AMA Relative Value Scale Update Committee (RUC) review process has resulted in the deletion or reallocation of pre-service and post-service times, hospital days, office visits, and discharge day management services. CMS notes that the AMA RUC has previously made recommendations to CMS to change the components of certain global surgical services. This includes changing the pre- and post-service physician time and mix of post-service E/M services associated with those global surgical services. However, there was no corresponding change in the work RVUs assigned to those services as a result. CMS's current proposal would make work RVU changes corresponding to the changes in pre- and post-service time and mix of post-service E/M services associated with the global surgical services in question.

AAFP supports the appropriate valuation of all services paid under the Medicare physician fee schedule. To the extent that certain services have had a change in their resource inputs without a corresponding change in the relative values assigned to them, AAFP supports CMS's decision to take a critical look at their current relative values. Absent compelling evidence to justify the current work RVUs in light of changes in resource inputs, we also support CMS's proposal to revalue those services.

##### **"23-Hour" Stay**

In the proposed rule, CMS states that it considers services that are performed in the outpatient setting and require a hospital stay of less than 24-hours to be outpatient services, and CMS recognizes the additional time associated with the patient evaluation and

assessment in the post-service period. CMS requests that the AMA RUC include the additional minutes associated with the patient evaluation and assessment in the post-service period in the RUC's recommendations to CMS.

CMS does not believe the current minutes assigned in the post-service period accurately reflect the total time required for evaluation and assessment of the patient. CMS believes the use of E/M codes for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre-service and intra-service work that would not be provided. Therefore, CMS will not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

We share CMS's concern regarding the valuation of outpatient procedures that typically involve less than a 24-hour hospital stay, and we support CMS's request that the RUC denote the additional minutes assumed to be associated with the patient evaluation and assessment in the post-service period in the RUC's recommendations to CMS for such services. Like CMS, we think the use of E/M codes as a proxy for such post-service physician work probably overstates the actual work typically provided. Accordingly, we also support CMS's proposal not to allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital.

### **Establishing Appropriate Relative Values for Physician Fee Schedule Services**

MedPAC has previously recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency review RVUs. In response, CMS seeks input on the following questions:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts?
- What should be the composition of a group of experts, and how could such a group provide expertise on services that clinician group members do not furnish?
- How would such a group relate to the AMA RUC and existing Secretarial advisory panels, such as the Practicing Physician Advisory Committee?

AAFP has supported MedPAC's recommendation that CMS establish a group of experts (including consumer and employers), separate from the AMA RUC, to help the agency review RVUs. Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and if supporting evidence was collected and analyzed not only by specialty societies but also by experts who were less invested financially in the outcome. Like MedPAC, we believe that such a panel would not supplant the RUC, but would augment it, and like MedPAC, we believe that such a panel would assist CMS by using the results of data analyses to identify potentially misvalued services. We anticipate that the RUC would be allowed to comment on any recommendations or findings of such a group.

In addition, we recommend that CMS examine in depth and issue a report on the process by which RVUs are established, reviewed, and adjusted under the Medicare physician fee

schedule. This would include the process of organizations, such as the RUC, on which CMS relies for recommendations in this regard.

The purpose of the study would be to analyze and determine whether the current process for consultation among organizations representing physicians offers an objective and balanced procedure for obtaining input on the establishment, review, and adjustment of RVUs.

Further, we believe the study should focus on the following:

- (A) The degree by which existing processes include equitable representation of primary care physicians and changes that may be necessary to reflect such representation;
- (B) The degree by which existing processes offer CMS expert and impartial input from physicians in medical specialties that provide primary care to patients with multiple chronic diseases, the fastest growing part of the Medicare population, and changes that may be necessary to reflect such input;
- (C) The degree by which existing processes include equitable representation of physician medical specialties in proportion to their relative contributions toward taking care of Medicare patients, as determined by percentages of Medicare billings per specialty, percentage of Medicare encounters by specialty, or such other measures of relative contributions to patient care as determined by CMS, and changes that may be necessary to reflect such representation; and
- (D) The degree by which existing processes, including application of budget neutrality rules, may unfairly disadvantage primary care physicians and other physicians who principally provide evaluation and management services.

MedPAC, the AMA, and others have observed that CMS routinely accepts 90% or more of the RUC's recommendations with respect to RVUs. Yet, we are not aware that CMS has ever critically examined the process by which the RUC generates those recommendations or has considered pursuing changes in that process. We believe that after 16 years of relying on the RUC process, CMS is overdue for an examination of the matter.

Finally, we recommend that CMS consider asking for transparency of voting by the RUC. Currently, RUC votes are done electronically so that how members of the RUC voted is not known to anyone except the individual members themselves. In this time of transparency throughout all areas of business and government, we believe that it makes no sense for the RUC voting to be "secret." We believe the process would benefit from greater openness and transparency in decision-making, and we would encourage CMS, as the primary recipient and user of the RUC's product, to insist on such transparency.

Medicare Improvements for Patients and Providers Act (MIPPA) Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Section 102 of MIPPA amends the law to phase out the statutory outpatient mental health treatment limitation. That limitation currently results in Medicare paying only 50% of the Medicare approved amount while the patient is responsible for the remaining 50%. When

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the limitation is fully phased out in 2014, Medicare will pay for outpatient mental health services at the same level (i.e., 80%) as other Part B physician services.

AAFP policy supports mental health parity: "The AAFP supports parity of health insurance coverage for patients, regardless of medical or mental health diagnosis. Health care plans should cover mental health care under the same terms and conditions as that provided for other medical care." We view Medicare patients as the primary winners under this provision, since they will have to pay progressively less out-of-pocket for outpatient mental health services until 2014. Physicians are held harmless as they may continue to collect the full Medicare allowed amount for these services. This provision is also positive for family physicians and other providers of outpatient mental health services, because they have to collect less from the patient. Accordingly, AAFP supports CMS's proposed implementation of Section 102 of MIPPA.

MIPPA Section 131(b): Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting Initiative (PQRI)

As proposed, CMS will pay a potential bonus of 2% of allowed charges billed in the applicable reporting period for successful PQRI reporting. CMS proposes to add a minimum patient sample of 15 patients (full year reporting) or 8 patients (half-year reporting) for one individual measure or measures group.

CMS further proposes to simplify registry-based reporting by removal of the requirement to report consecutive patients (i.e., reporting of patients in order seen). Physicians will be able to successfully report on any patients who meet the numerator and denominator criteria for the measure or measures group being reported during the reporting period regardless of date seen.

CMS also proposes a large group practice (i.e., over 200 eligible professionals) PQRI reporting option. Large groups may report and receive a bonus based on the group's overall PQRI success rather than by individual physician or provider. Performance rates of participating groups will be posted on CMS's web site for consumer information. CMS will be creating a database for participating large groups to use in entering their PQRI data. If successful with groups of this size, CMS may open this option to smaller group practices in the future.

Finally, CMS indicates that electronic health record (EHR)-based reporting may be an option in 2010. CMS expects to address this in the final rule but has made provisions for the option by selecting 10 measures that may be reported if EHR-based reporting is approved.

The AAFP has been a supporter of PQRI, although we have expressed concerns regarding CMS's administration of the program. We have also encouraged CMS to make the program more "user friendly" and more timely in its feedback to participating physicians. The simplified registry reporting and potential EHR-based reporting would seem to be steps in the right direction in this regard. We believe that simplified registry reporting may make this option more accessible to family physicians. Likewise, the potential for EHR-based reporting

may also facilitate family physician participation in PQRI, at least for those family physicians that have an EHR. Accordingly, we support CMS's proposals related to PQRI for 2010.

Though not addressed by CMS in this proposed rule, we also ask that CMS consider and recommend to Congress a modified version of the proposed option presented by the Senate Finance Committee in the April 29, 2009, "Description of Policy Options, Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" to add a new participation option allowing eligible professionals to receive PQRI incentive payments for three successive years if, on a triennial (every three year) basis, the physician (1) participates in a qualified American Board of Medical Specialties certification, known as the Maintenance of Certification or MOC, or equivalent programs, and (2) completes a qualified MOC practice assessment.

The proposal applies the following definitions:

1. Qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program would mean a continuous assessment program to advance quality care and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice;

2. MOC programs or equivalent other programs must include the following assessment components:

(a) Professional standing – Programs must require physicians to maintain a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada. A qualified MOC program must also include a survey of patient experience with care;

(b) Lifelong learning and self-assessment – Programs must require physicians to participate in educational and self-assessment programs that require an assessment of what was learned;

(c) Demonstration of cognitive expertise – Programs must require physicians to demonstrate, through a formalized, secure examination, that they have the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty;

(d) Practice performance assessment - A practice assessment must include an initial assessment of physician clinical quality compared to peers and national benchmarks. It also needs to include implementation of a quality improvement intervention to address an identified practice weakness, and a reassessment of performance in the area focused on for improvement; and (e) An audit process that meets standards defined by the Secretary.

3. Qualified MOC practice assessment would mean an initial assessment of a participant's practice, designed to demonstrate the physician's ability to use best evidence and practices in comparison to peers and national benchmarks, and apply best evidence and consensus recommendations to improve quality care using follow-up assessments. Such assessment tools must:

(a) Use National Quality Forum (NQF) national endorsed measures, where appropriate, to derive a set of clinical metrics that are at least equivalent in both the methods and measures used to those of the PQRI program; and

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(b) Require the physician to implement a quality improvement intervention to address a practice weakness identified in the performance assessment report, and then to remeasure to assess performance after this intervention.

The AAFP supports this proposal that would coordinate with the American Board of Family Medicine's continuous assessment program, MOC Part IV that is completed every three years.

We encourage CMS to actively review and advocate for PQRI options such as this which allow physicians to provide evidence of continuous quality improvement with less administrative burden and costs than what is offered through the current PQRI options.

#### MIPPA Section 131(c): Physician Resource Use Measurement and Reporting Program

Section 131(c) of MIPPA established a Physician Feedback Program using Medicare claims and other data to provide confidential feedback reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. In the proposed rule, CMS describes its implementation of Phase I of this program and solicits comment on the design and elements of the sample resource report used in Phase I. CMS also solicits comments on its expansion plans related to Phase II, including proposals to add reporting to groups of physicians and to use quality measures in addition to resource use measures. CMS has implemented the program in only a dozen sites thus far and indicates that it will add "a limited number of new locations" for 2010. There are currently no rewards or penalties attached to these reports.

The AAFP commented extensively on this program in its comments on the final rule on the 2009 Medicare physician fee schedule. In general, the AAFP is not opposed to the program, as long as it is conducted consistent with AAFP policies on "Performance Measures Criteria" and "Physician Profiling, Guiding Principles." We have enclosed a copy of both policies for your information.

As CMS seeks to refine and improve the program, we would offer the following suggestions for your consideration:

- Include quality data along with the utilization data to make the data meaningful to those who receive them. Looking at costs alone is insufficient. You have to look at the quality compass--from patient experience to clinical outcomes--to make any meaningful comparison.
- Help physicians understand what these data mean to them and how they can improve their utilization, effectiveness, or quality based on the data. The sample resource use report that we have seen is over 30 pages, including methodology and glossary. Receiving a 30-page document such as this may be a bit overwhelming for the majority of physicians unless it is accompanied with some suggestions about what they can do to have more positive results.

- Strive for accountability and transparency in episode treatment grouping. CMS's current use of a proprietary black box episode treatment grouper (ETG) thwarts accountability and transparency. Further, the science of episode treatment grouping is still rudimentary. ETGs work best for discreet incidents such as hip fracture where all the cost attributed to that problem are fairly easy to assign. When the issue is chronic illness or multiple co-morbidities, then the methodology becomes less useful. In short, issues such as attribution, defining episodes and accounting for multiple chronic diseases are not very refined in current ETG methods. Episodes might work if transparent and based on something like the International Classification of Primary Care, where a trail can be established and attribution can be more granular.

MIPPA Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

**Provision:**

Section 131(d) of MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the physician fee schedule. It also requires the Secretary to submit a report to the Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The report is due by May 1, 2010. The proposed rule provides an update on CMS's efforts in this regard and solicits original comments on development of the VBP plan for physician services and the related report to Congress. CMS is particularly interested in comments on the appropriate level of accountability and appropriate data submission mechanisms.

The AAFP recognizes the urgency to improve both efficiency and quality in the delivery of medical care, including VBP as one approach. However, given the technical, legal and ethical challenges in designing and implementing VBP, it is imperative that physician measurement processes used in VBP should be transparent and adhere to the AAFP policies on "Performance Measures Criteria," "Physician Profiling," "Data Stewardship," and "Transparency." A copy of each of these policies is enclosed.

The AAFP supports VBP programs that adhere to these principles:

1. Focus on improved quality of care
2. Support the physician/patient relationship
3. Utilize performance measures based on evidence-based clinical guidelines
4. Involve practicing physicians in program design
5. Use reliable, accurate, and scientifically valid data
6. Provide positive physician incentives
7. Offer voluntary physician participation

Based on these principles, the AAFP will use its influence to support and encourage the utilization of the following guidelines:

1. The purpose of VBP should be to improve quality of care to patients and their communities.

2. VBP should enhance adherence to evidence-based practice guidelines and measures endorsed by the National Quality Forum.
3. VBP should be based on reliable, valid, verifiable, and transparent data.
4. VBP should be flexible in the following ways:
  - Responsive to community needs, preferences and resources
  - Adaptable to different practice organizational models, structures of care, and physician specialties
  - Responsive to individual preferences and socio-cultural backgrounds
  - Respectful of differences in adoption of health information technology (HIT) while encouraging its effective spread
5. VBP should be accountable to purchasers, consumers, and providers.
6. VBP should encourage the establishment of robust patient-centered medical homes, including the systems and HIT that are structurally necessary.
7. VBP should involve multidimensional and comprehensive measurement.
8. VBP should advance knowledge of effective and efficient episodes of care.
9. VBP should recognize explicitly the tradeoffs in value decisions.
10. VBP should be sensitive to issue of health disparities.
11. VBP should create alignment of incentives among clinicians, systems, patients, and communities.
12. VBP should recognize, disclose and balance the administrative burden and costs to clinicians and the health systems of measurement and participation in VBP with the incentives of the program.
13. VBP should recognize the path of quality improvement in the medical practice and system, and not solely the outcome.

MIPPA Section 132: Incentives for Electronic Prescribing (E-Prescribing) – The E- Prescribing Incentive Program

The e-prescribing incentive created by section 132 of MIPPA offers physicians an opportunity to earn a 2% bonus on their Medicare allowed charges. Physicians may report both PQRI measures and the e-prescribing incentive code using the same registry, if they use the registry reporting option.

CMS has simplified the reporting requirements for e-prescribing in 2010. Specifically, they have proposed to reduce the number of G-codes for submission in 2010 to only one code. This code is for when at least one prescription is sent electronically. Also, instead of requiring reporting on 50% of eligible visits, CMS proposes that a physician must report that at least one prescription was sent electronically at 25 visits in a year. This reduces the burden on reporting as physicians do not have to report on visits where no prescriptions were written (or not sent electronically), and it moves CMS closer to being able to use Part D claims data to do the reporting (i.e. physicians would not have to report).

CMS has further increased access to the e-prescribing incentive by proposing multiple ways to submit the e-prescribing measure, including through claims, registries, and EHRs. This is important, because it allows for integration into EHRs for those that have one, but it also allows stand-alone e-prescribing practices to submit through claims.

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Finally, CMS has proposed to expand the visits that qualify under the e-prescribing incentive program to include professional services outside of the practice, including home care and skilled nursing care. This change yields recognition and equity for physicians who care for Medicare patients in these settings. It is also consistent with previous AAFP advocacy that encouraged CMS to include home care codes in the denominator.

The AAFP supports incentives that promote e-prescribing, and the proposed changes to the Medicare e-prescribing program all appear to be headed in the right direction. The simplified reporting and multiple avenues for reporting are both improvements to the program. That said, e-prescribing is only one small aspect of health information technology (HIT), and there should be an adequate focus on and efforts toward creating a conversion to broadly use HIT, including EHRs, consistent with AAFP principles.

#### MIPPA Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Under MIPPA section 135, beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services to a supplier who is accredited by an accreditation organization designated by the Secretary of Health and Human Services. These services are defined to include only diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography, which are generally owned and operated by hospitals, larger group practices and independent diagnostic testing facilities. CMS estimates the prorated average annual accreditation fee is \$1,666, and accrediting agencies will be required to have plans for reducing the burden and cost of accreditation to small and rural suppliers.

As we review CMS's proposed implementation of this provision, we note that the relative impact on small and rural providers will likely be greater than on other owners, providers, and suppliers of this technology, which is acknowledged and accounted for in the proposed rule. We also note that some small number of family physician practices may wholly or partially own these technologies and thus be defined as a supplier and subject to the accreditation requirement. However, the anticipated impact on family physicians is minimal, and the AAFP does not have a position on accreditation of providers of advanced imaging services. Accordingly, we have no objections to CMS's proposed implementation of MIPPA section 135.

#### Clinical Laboratory Fee Schedule: Signature on Requisition

In the proposed rule, CMS restates and invites public comments on two long-standing policies related to clinical diagnostic laboratory tests. The first policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule; however, it must be evident, in accordance with CMS regulations at 42 CFR 410.32(d)(2) and (3), that the physician ordered the services. Regulations at 42 CFR 410.32(d) specify that the physician or qualified non-physician practitioner (NPP) who ordered the service must maintain documentation of medical necessity in the beneficiary's medical record.

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The second policy is that a written order for diagnostic tests, including those paid under the clinical laboratory fee schedule and those that are not paid under the clinical laboratory fee schedule (for example, that are paid under the physician fee schedule such as X-rays) must be signed by the ordering physician or NPP.

For purposes of these policies, CMS makes a distinction between an “order” and a “requisition.” In its Medicare Benefits Policy Manual, CMS defines an “order” as a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility; or
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

The policy in question concerns only the first form of communication (i.e., written orders). In turn, CMS defines a “requisition” as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. From CMS’s perspective, it may contain patient information, ordering physician information, referring institution information, specifics about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and check boxes for test selection. CMS believes a requisition is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients.

Thus, CMS believes that a written order, which may be part of the medical record, and the requisition are two different documents, although a requisition that is signed may serve as an order. CMS invites comments on this distinction as well.

Although somewhat convoluted, CMS’s distinction between an “order” and a “requisition” makes sense to us if understood in the following way. An “order,” as defined by CMS, represents a physician’s (or NPP’s) request for a diagnostic test for a beneficiary. As such, it may take multiple forms (i.e., written, verbal, electronic) and be transmitted in different ways. One way to transmit an order is a “requisition,” which CMS defines as physical paperwork that relays an order from a physician (or NPP) to the entity providing the diagnostic test.

With this distinction in mind, we are supportive of both policies on which CMS solicits comments. Namely, we support CMS’s policy that a written order for diagnostic tests, including those paid under the clinical laboratory fee schedule and those that are not paid under the clinical laboratory fee schedule should be signed by the ordering physician or NPP. The request for a diagnostic test represents part of the physician’s plan for the patient,

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which is part of the patient's medical record. As such, when the request is in writing, a physician signature would be appropriate and likely easily generated, assuming the physician is writing the order.

We also support CMS's policy that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule. To the extent a "requisition" is simply a paper mechanism for transmitting an order and more administrative in nature, it is less likely to be generated or handled by the physician. Thus, to require a physician signature on a requisition for clinical Diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule would be an added and unnecessary burden on physicians, from our perspective.

#### Physician Self-Referral

In the proposed rule, CMS proposes to revise the second sentence of 42 CFR 411.354(c)(3)(i) to clarify some confusion regarding its application. The regulations at 42 CFR 411.354(c) are part of the regulations implementing the physician self-referral law, and 42 CFR 411.354(c) governs when a physician "stands in the shoes" of his or her physician organization and may, therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing designated health services.

The second sentence of 42 CFR 411.354(c)(3)(i) currently reads:

For purposes of applying the exceptions in §§ 411.355 and 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the "parties" to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).

Apparently, this language has caused some confusion within the industry, so CMS proposes to clarify it by revising it to read as follows:

When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated "between the parties" are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

This particular provision has not been a source of confusion or consternation to family physicians of which we are aware. That said, the proposed clarification by revision appears reasonable to us and seems consistent with the intent of the regulations and statute. Accordingly, we have no objections to CMS's proposed revision.

#### Physician Fee Schedule Update for Calendar Year (CY) 2010

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CMS proposes to remove physician-administered drugs from the definition of “physicians’ services” for purposes of computing the Sustainable Growth Rate (SGR) and for purposes of calculating the levels of allowed expenditures and actual expenditures. This applies both prospectively and retrospectively to the 1996/1997 base year. This proposal will not change the CY 2010 update, which CMS currently estimates to be -21.5%, under current law. It also will not “fix” the underlying problem posed by the use of the SGR. Instead, the proposal will reduce the number of years in which physicians are projected to experience a negative update under current law and thus reduce the cost of “fixing” the SGR problem, if Congress decides to do so.

We note that all physicians paid under the Medicare physician fee schedule benefit from the proposal to remove physician-administered drugs from the definition of “physicians’ services.” Likewise, all physicians paid under the Medicare physician fee schedule will be negatively affected by a -21.5% update in the conversion factor, if Congress allows it to occur.

As noted in the proposed rule, growth in the cost of prescription drugs has far outpaced growth in the cost of other physicians’ services and has become an increasing percentage of the volume of Medicare spending. Consequently, spending on physician-administered drugs has contributed significantly to the deviation between target and actual spending as well as to the large projected reductions in future fee schedule updates. Removing physician-administered drugs from the definition of “physicians’ services” for purposes of the SGR and calculation of the updates will help reduce the deviation and thus reduce the number of years of projected negative updates under current law.

AAFP has consistently advocated for removing physician-administered drugs from the definition of “physicians’ services” for purposes of the SGR and calculation of the fee schedule updates. From an AAFP perspective, drugs that are not paid for by the Medicare physician fee schedule do not belong in the formula to determine the fee schedule rates. Thus, AAFP supports CMS’s proposal and hopes that the agency will continue to work with Congress to avert what would be a disastrous reduction in Medicare physician fees if the -21.5% update in the conversion factor were allowed to occur.

In closing, we would like to thank CMS and the Obama Administration for the emphasis placed on the value of primary care in the proposed physician payment rule. It is an appropriate and long-overdue acknowledgment of the role primary care plays in our nation’s health care delivery system and the Medicare program in particular. Our members are grateful that this proposed rule shows such a strong commitment to the value of primary care.

It is clear to us that this Administration has proposed bold steps toward aligning incentives by adjusting relative values and bringing a degree of rationality to the payment formula. We appreciate the thought and the work that went into the proposed rule.

We appreciate this opportunity to comment on matters related to the Medicare Physician Fee Schedule. As always, the AAFP looks forward to working with CMS in its continued efforts to ensure access to appropriate physician services.

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Sincerely,

A handwritten signature in black ink, appearing to read "JK MD". The signature is stylized with large, overlapping loops for the letters "J" and "K", and "MD" written in a smaller, more standard script to the right.

Jim King, M.D.

Board Chair

Enclosures:    AAFP policy on "Performance Measures Criteria"  
                  AAFP policy on "Physician Profiling, Guiding Principles"  
                  AAFP policy on "Data Stewardship"  
                  AAFP policy on "Transparency"

## **Performance Measures Criteria**

Physician level clinical performance measures may be used for local improvement efforts, public reporting, accountability or pay for performance programs. The AAFP participates in the Physician Consortium for Performance Improvement sponsored by the American Medical Association and works closely with the National Quality Forum (NQF), the National Committee on Quality Assurance (NCQA), and the Ambulatory Care Quality Alliance (AQA), all of which are involved in performance measurement development, endorsement or implementation.

The AAFP encourages the utilization of performance measures that are consistent with the criteria described below for evaluating and improving patient care.

### ***Statement of Principles***

The American Academy of Family Physicians is committed to promoting quality, cost-effective health care. The Academy supports health care quality improvement endeavors, including the development and application of performance measures (whether single or in aggregate) which have the following attributes:

- Aimed at improving important processes and outcomes of care in terms that matter to patients;
- Responsive to informed patients' cultures, values and preferences;
- Based on best evidence and reflect variations in care consistent with appropriate professional judgment;
- Are practical given variations of systems and resources available across practice settings;
- Are cognizant of the burden of data collection, particularly in the aggregation of multiple measures;
- Assess patient well-being, satisfaction, access to care, and health status; and,
- Are updated regularly

The spirit in which performance measures are developed and applied should be one of continuous improvement. The primary purpose of performance measurement should be to identify opportunities to improve patient care. Some measures will have usefulness for accountability, public reporting or pay for performance programs.

Only the most evidence-based, widely accepted, and important measures should be used for accountability, pay for performance or other significant decisions. When comparisons are made, they should be risk-adjusted, consider differences in denominator populations and account for variations in patient preferences, values, access, and availability of services.

The value of the application of performance measures should also be assessed in terms of physician, practice and health system burden, economic costs and savings, and impact on patient-oriented outcomes that matter.

The AAFP participates in the development of performance measures by nominating family physicians to represent the membership on pertinent workgroups. This work is accomplished primarily through the American Medical Association-sponsored Physician Consortium for Performance Improvement. The Consortium has developed Physician Performance Measurement Sets which offer clinical performance tools to support physicians in their efforts to enhance quality of patient care.

The following criteria shall be used by the AAFP to evaluate performance measures.

### ***Importance***

**Grounded in science.** The measure should be evidence-based, explicit, and reflect the degree of scientific certainty. The aim of the measure should be to improve outcomes that are meaningful to patients. When intermediate processes of care are assessed, the causal pathway to improved patient-oriented outcomes should be strong.

**Substantial potential for improvement.** A significant gap should exist between optimal and current clinical practice. The gap should be amenable to substantial improvement by means of feasible interventions.

**Severity and prevalence.** The condition and its prevalence in the population should be significant enough to justify targeting the condition for improvement.

**Substantial impact.** The measure should be patient-centered, hold the potential for substantial impact on the health status, health outcomes, and satisfaction of individual

patients and be capable of maintaining and/or improving the health of a community or population of patients.

**Relevant.** The measure should be important to physicians and their patients and should be amenable to evaluation.

**Improve value.** Measures should have the potential to improve value of health services for patients, plans, and purchasers of health care.

### ***Measurability***

**Accurate and reliable.** The measure should be clearly defined, reliable, and consistent across different practice settings.

**Valid.** The measure is scientifically valid and based on high quality evidence of efficacy and effectiveness. There is face validity, indicating obvious appropriateness or agreement by experts; and, construct validity, indicating a comprehensive picture of the care being provided. Comparisons should be statistically valid, risk-adjusted and account for differences in denominator populations or patient settings. The translation of best evidence of effectiveness into practice should be demonstrated.

**Precisely defined and specified.** The measure specifications should include:

- The rationale or intent of the measure;
- A description of the performance measure population;
- A well-defined denominator with clear inclusion and exclusion criteria;
- Defined sampling procedures, when applicable;
- Defined data elements and data sources;
- Instructions for collecting data for the measure; and,
- Provide that data are able to be verified by the practice/physicians that is being assessed.

**Easily interpreted.** The measure can be interpreted consistently by those using the information.

**Risk adjusted.** If the measure is intended for meaningful comparison with the

performance of others, it should be risk adjusted, as possible and appropriate. Consideration should be given to variations given differences in practice settings, patient preferences, cultural and social factors, and appropriate physician-patient decision-making. While adjustment should consider characteristics that impact health outcomes among different populations, including those beyond a health system's control, it is important to retain accountability for developing systems and processes that strive for continuous quality improvement.

### ***Achievability***

**Improvement attainable.** The health outcome goal of the measure can be achieved, or an improvement can be accomplished, in the settings in which it is applied.

**Reasonable cost.** The measure should not impose an inappropriate financial burden on those collecting the data. The cost of collecting the data and affecting improvements should be justified by impact on patient-oriented outcomes. There should be alignment between the cost of data measurement and performance improvement and funds dedicated to these processes.

**Feasible.** The measure should be feasible for a physician to meet. For example,

- Data for the measures are readily available;
- Patient confidentiality must be maintained;
- The number of required measures is reasonable;
- Realistic time frames are allowed for data collection;
- To the extent possible, measures and specifications should remain consistent over a period of time long enough to complete a cycle of improvement;
- Instructive materials should accompany performance measures;
- Consideration is given to variation given differences in practice settings, patient preferences, cultural and social factors, and appropriate physician-patient decision-making;
- Performance improvement can be implemented and maintained with reasonable effort; and,
- The measurement is current and cost-effective.

# Physician Profiling, Guiding Principles

## ***Preamble***

The AAFP defines physician profiling as an analytic tool that uses epidemiological methods to compare physician practice patterns across various quality of care dimensions (process and clinical outcomes). Cost, service and resource utilization data are dimensions of measuring quality, but should not be used as independent measures of quality care. The ultimate goal is to deliver high quality, evidence-based care to improve clinical outcomes.

It is important to recognize that physician profiling is not intended to be used to address issues of physician competency, including the dimensions of medical knowledge, skills and competence. Such issues should be addressed by the appropriate public and private credentialing bodies that exist for these purposes.

AAFP believes that transparency in health care cost and quality information to physicians, patients, and employers is important and supports such efforts provided that the data aggregation and analysis is consistent with the AAFP [Performance Measures Criteria](#) policy. These criteria encompass the framework in which physician profiling data is collected, analyzed, and utilized.

Family physicians must have an opportunity to review payer performance profiles prior to them being publicly reported. Payers must establish and communicate a reasonable, formalized reconsideration process in which physicians can appeal their performance rating/designation(s).

## ***Guidelines***

Ideally, any physician profiling system/program should:

1. Have as its purpose to assess and improve the quality of patient care and clinical outcomes.
2. Clearly define what is being measured.

3. Select measurement goals which are actionable so that physicians can easily interpret and act as needed to achieve the stated measurement goal.
4. Involve physicians in the development of performance measures, feedback process, and appeals process.
5. Explicitly describe the data sources on which measurement is based, e.g., administrative/claims, medical records, surveys, etc.
6. Clearly report on the validity, accuracy, reliability and limitations of data utilized when reporting profiling results and when providing physician feedback. This may include:
  - a. detailing the steps taken to ensure data accuracy and fair physician attribution of costs of care,
  - b. clearly defining the peer group against which individual physician performance is being measured/compared,
  - c. disclosing data limitations, e.g., the impact of an "open access" product in which the primary care physician may have little or no control over resource utilization,
  - d. describing the assignment of patient populations to either individual or physician groupings,
  - e. using an appropriate sample size to assure validity,
  - f. including appropriate risk adjustment and case mix measures, and
  - g. establishing and reporting data using meaningful time periods for data collection.
7. Utilize criteria for comparison purposes that are based on valid peer groups, evidence-based statistical norms and/or evidence-based clinical policies.
8. Identify individual patients who are not receiving indicated clinical interventions and provide interventions to improve physician performance relative to stated measurement goals.

# Data Stewardship

The amount of health data generated in digital form, stored in electronic databases internal or external to physician offices, and transmitted to and from family physicians' practices continues to grow exponentially. The following data stewardship guidelines are intended to facilitate the appropriate collection, storage, transmission, analysis, and reporting of these data. Execution of these processes must be in a manner that is ethical and protects the interests, including the privacy and confidentiality, of both the patients and physicians generating this data.

These guidelines specifically address the conditions under which de-identified clinical and administrative data derived from physicians' electronic systems is collected and used by third parties, e.g., public and private health plans, retail pharmacies, hospitals, clinical laboratories, and intermediaries, such as clearinghouses or application service providers, who store personal health data in remote systems.

NOTE: Nothing herein or below shall be construed as contravening the standards for health information contained in HIPAA relating to privacy, confidentiality, or security of personal health information. Generally, the recommendations below pertain to de-identified and aggregated data only.

1. Submission of data from physician practices to third parties must be voluntary.
2. Physician practices must reserve the right to submit data to entities of their own choosing, either in addition to or as part of the chain of data submission (e.g., to payers, health plans, or community data repositories), for purposes such as quality improvement, performance measurement and research programs.
3. A framework for managing patient and physician consent, with appropriate granularity, must be established and maintained. This would include the ability of independent third parties to audit data use/release and a responsibility to inform affected parties regarding inappropriate use/release of their data.
4. Third parties who collect, store, manage, or analyze data derived from physicians' EHRs or other practice systems, must provide participants with a clear, written policy detailing the intended uses of such data prior to any data submission. In addition, any change in the policy or intended use of such

data, must be relayed to participating practices prior to further submission and use of such data. This notification must be written, provided in a timely manner, and allow physician practices the right to decline those uses.

5. Third party use policies must clearly distinguish between quality improvement, performance measurement and research uses of submitted data. Allowable and non-allowable uses of data must be delineated in addition to prioritization of allowable data uses.
6. Third parties should share with physician practices any analysis of the practice's data, whether individually or in aggregate, that has the potential to improve quality, safety, or efficiency in that practice.
7. To maximize care quality and patient safety, data submitted to third parties, for the purposes of quality improvement, performance measurement or research, should be considered within the domain of peer review, and as such, be confidential, protected, and not subject to disclosure or discovery.
8. Data quality issues must be evaluated and addressed at every step from collection to reporting. Data quality may include accuracy, validity, integrity, meaning, consistency and completeness. Poor quality data must not be allowed to propagate throughout the system, degrading patient safety and care quality.
9. Adoption of standards defining data capture, semantics, representation, and messaging are needed for collection, transmission, storage, and analysis of these data and associated metadata. These standards would include core data sets, controlled vocabularies, and data structures.
10. Storage of these data must adhere to industry and regulatory standards for data of similar criticality and confidentiality. Retention and destruction of data must comply with legal requirements and the rights of data supplies.
11. A process must be in place for physician practices to validate any data after transmission as well as any analyses and resultant reports. There must be adequate time for practices to perform this validation.
12. Third parties must be responsible for the timeliness and completeness of the reports back to physician practices. Though a summary report is desirable, practices must have the ability to drill down into areas of interest and have full access to applicable data, methods, and results.
13. Payers who have collected data for quality or performance measurement purposes should allow real-time access to these data by the originating physician practices. The purpose of the data is to improve quality and safety, requiring the availability of actionable data at the point, and time, of care.
14. Data required for submission must be clearly defined in both purpose and format. Only data critical to fulfilling the stated objectives should be required.
15. Use of industry standards for networking and data sharing allows easy access to the reporting data either via the web or integrated into other applications through technologies such as application programming interfaces (APIs). To afford real-time access to the data and promote point of care use, reporting to participating physician practices should be at least web-based.

16. Risk and severity issues must be considered in data analyses to maximize the value of quality and performance data and resultant reports.

# Transparency

The American Academy of Family Physicians (AAFP) believes that transparency in health care refers to reporting information which can be easily verified for accuracy. Both data and process should have transparency and an explicit disclosure of data limitations. Transparency in health care includes, but is not limited to, easy availability of:

- payers' payment policies
- payers' claims adjudication software logic edits
- payers' fee schedules
- payers' clinical policies
- payers' data analysis methodology and performance measures used in rating
- physician performance
- reporting of physician health care cost and quality information