



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 29, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1524-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012

Dear Dr. Berwick:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 100,300 family 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 2012. The Centers for Medicare & Medicaid Services (CMS) published the proposed rule in the *Federal Register* on July 19, 2011 and invited comments on several Medicare payment policies.

We recognize that the proposed fee schedule implements laws as passed by Congress, but we would like to ensure that CMS is aware that the AAFP is also seeking legislative changes that would impact this regulation. We have called on Congress before 2012 to pass a five-year extension of Medicare physician payment updates at current rates that includes a payment rate that is at least 3 percent higher for primary care physicians providing primary care services, and that doubles payments associated with the Primary Care Incentive Program. The AAFP also will continue to work with Congress to insure the work Geographic Practice Cost Indices (GPCI) issue is addressed and we encourage CMS to work with Congress to maintain the work GPCI floor, or even provide a payment boost, in areas designated as Medically Underserved Areas/Populations and Health Professional Shortage Areas. The AAFP convened a task force regarding payment methodologies for primary care and our first meeting occurred in August with CMS staff attending as an observer. We will have detailed recommendations by Spring.

To improve the final 2012 Medicare physician fee schedule regulation, the AAFP offers recommendations related to this proposed rule. A summary of key recommendations include urging that CMS:

- Validate currently assigned physician work and time values based on a valid documentation sample.
- Consolidate the formal five-year review of work and practice expense with the annual review of potentially misvalued codes.
- Establish a more timely review of misvalued services. The AAFP is encouraged that the agency has included evaluation and management services in its ongoing efforts to identify, review, and validate potentially misvalued codes.

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- Continue participation in the AAFP- created and funded task force to value primary care payment appropriately. In the meantime, we believe that it would not be productive to ask the RUC to revalue evaluation and management services under the same structure, procedures, and methodology that it used to establish the current values. It is clear from the initial task force meeting that significant methodology flaws need to be addressed.
- Finalize the proposal to extend the multiple procedure payment reduction (MPPR) to the professional component of advanced diagnostic imaging services (i.e., CT, MRI, and ultrasound) beginning in 2012 but continue further studies and discussion before CMS considers any proposal to extend the MPPR to the technical component of all diagnostic tests.
- Wait for the Institute of Medicine to finish its study on Geographic Practice Cost Indices values before prematurely finalizing these proposed changes.
- Finalize the decision to add smoking cessation services to the list of approved telehealth services.
- Not add a required health risk assessment (HRA) to the annual wellness visits (AWV) provided in 2012
- Continue offering as many Physician Quality Reporting System (PQRS) reporting options and timeframes as possible to facilitate successful participation by small to medium sized groups.
- Consider virtual groups to form for purposes of the PQRS.
- Significantly accelerate the requirement definition and review process for qualifying PQRS registries.
- Take some level of responsibility and hold vendors accountable for successful data submission.
- Minimize administrative burdens if CMS finalizes a proposal to require family physicians and other specified physicians to report on PQRS core measures focusing on cardiovascular conditions and to only use measures that possess National Quality Forum endorsement.
- Provide more timely access to PQRS feedback reports.
- Not base the 2015 PQRS penalty using 2013 performance.
- Not prematurely create a physician compare website when standardized metrics for items like assessment of safety, effectiveness and timeliness of care, and assessment of continuity and coordination of care do not yet exist
- Not prematurely scale up efforts with Phase III of the Physician Resource Use and Measurement Reporting Program when underlying problems with Phase I and II reports have not been satisfactorily addressed.
- Not require family medicine practices that are wholly owned or wholly operated by a hospital to hold Medicare claims for at least three days before submitting them in order to determine or have the hospital inform them if a patient had a clinically related inpatient admission.

Section I.B. Components of the Fee Schedule Payment Amounts

Conversion Factor for 2012

The *Medicare and Medicaid Extenders Act* of 2010 provided for a 1-year zero percent update resulting in the 2011 conversion factor currently being \$33.9764. Since this 1-year extension expires at the end of 2011, CMS currently estimates that the statutory formula used to determine Medicare physician payments will result in a 2012 conversion factor of \$23.9635 which represents a physician fee schedule update – a decrease of 29.5 percent.

The AAFP continues to call on Congress to prevent these drastic payment cuts and to end the practice of enacting retroactive “fixes”. Congress must reform Medicare payment so that patients know they have access to care, physicians can be assured of appropriate payment for their expertise and the healthcare system can anticipate and control costs.

In a [statement](#) issued when the fee schedule was released, the AAFP urged Congress before 2012 to pass a five-year extension of Medicare physician payment updates and to build the primary care physician

workforce and reduce the widening difference between the payment for cognitive primary care services and procedural subspecialty services, include a differential payment rate that is at least 3 percent higher for primary care physicians providing primary care services, and double payments associated with the Primary Care Incentive Program. Research has consistently demonstrated that increased prevalence of primary care physicians effectively improves health outcomes and that implementation of the patient centered medical home is the model that best meets the goals of improving the quality of care and helping to restrain health care costs. This comprehensive model provides not only the first contact a patient has with the healthcare system, but also the preventive care, management of chronic conditions and coordination of services provided by all the other members of a patient's healthcare team. CMS should work with the medical community to develop and implement the patient-centered medical home, reward prevention and wellness, eliminate fragmentation and duplication, and produce a cohesive system of care that prevents unnecessary complications from acute or chronic illness, hospitalizations, and other avoidable expenses.

Section II.B. Potentially Misvalued Services under the Physician Fee Schedule

2.c. Validating RVUs of Potentially Misvalued Codes

Section 3134(a) of the *Affordable Care Act* added a new section 1848(c)(2)(L) to the *Social Security Act*, which specifies that the Secretary shall establish a formal process to validate relative value units (RVUs) under the physician fee schedule. In the proposed rule on the 2011 Medicare physician fee schedule, CMS solicited public comments on possible approaches and methodologies that it should consider for a validation process.

In the 2012 proposed rule, CMS provides an additional opportunity for stakeholders to submit comments on data sources and possible methodologies for developing a validation system for the fee schedule. CMS is particularly interested in comments regarding data sources and studies that may be used to validate estimates of physician time and intensity that could be factored into the work RVUs, especially for services with rapid growth in Medicare expenditures. CMS also solicits comments regarding the Medicare Payment Advisory Committee's (MedPAC) suggestion of "collecting data on a recurring basis from a cohort of practices and other facilities where physicians and non-physician clinical practitioners work."

As we [noted](#) (pages 3-7) in response to CMS's proposed 2011 Medicare physician fee schedule, this is a critical issue as several recent studies show that the widening income gap between cognitive and procedural physician specialties is dramatically reshaping the physician workforce by influencing both career choice by students and graduate medical education build-up by teaching hospitals. Effectively revaluing primary care and other cognitive codes will be essential to ensuring that there are a sufficient number of primary care physicians in the future.

Early task force discussions have made it clear that validating currently assigned physician work and time values based on a valid documentation sample will require a thorough examination of basic assumptions and data sources. For example, data for work complexity only allows entry of three diagnoses while we know from multiple other data sources that there are commonly up to thirteen diagnoses addressed during one visit.

The critical shortage of primary care physicians, who best manage the complexities of chronic care, results from the current flawed payment structure. The AAFP urges CMS to take several short and long term actions to improve the currently existing payment disparity:

- Institute payment for currently "non-covered services" such as:
 - Anticoagulation management;
 - Telephone calls
 - On-line medical evaluation

- Team conferences
- The RUC reevaluated the outpatient E&M codes in 2007. Instead of asking the RUC to do this again, something discussed in several places throughout this letter, the AAFP believes CMS should review the original Summary of Recommendation forms submitted to the RUC and adopt the median RVU's. These values were substantially reduced by the RUC prior to adoption.
- Reimburse G-codes relating to provisions of the Patient Centered Medical Home (PCMH), as originally anticipated in the Medicare Medical Home Demonstration. In order to assure that PCMH principles are followed, medical practices would need to be certified by NCQA or other agencies acceptable to CMS.

In regards to future RVU validation efforts and CMS's call for comments on possible approaches and methodologies for a validation process, especially as it relates to estimates of physician time and intensity, we would again offer the following suggestions for CMS's consideration.

First, services with 10 and 90-day global periods typically include a number and level of post-service hospital (where appropriate) and office visits, the time and value of which are assumed to be included in the total value of the global period. To the best of our knowledge, CMS has never validated this post-service work in services with 10 and 90 day global periods. It might be instructive for CMS to review a statistically valid sample of associated medical records for selected high volume 10 and 90-day global services to validate whether or not the post-service visits assumed to be included in the RVUs of the global service are, in fact, typically provided at the frequency and level assumed.

On a related note, Cromwell, et al. (Cromwell, Jerry, et al., "Missing Productivity Gains in the Medicare Physician Fee Schedule: Where Are They?," *Medical Care Research and Review*, published [online](#) June 16, 2010), present an empirical study showing more post-surgery handoffs by surgeons. That study suggests that surgeons are increasingly delegating postsurgical visits to other physicians, nurse practitioners, and physician assistants. Thus, in addition to validating the number and level of post-service visits, the time and value of which is assumed to be included in the value of the global service, CMS may also want to validate that the physician or group receiving those RVUs is, in fact, providing the post-service visits.

Second, physician service times, particularly intra-service times, are captured in other venues besides the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) survey process. For example, hospital operating room logs often record surgical times, and there is peer-reviewed literature on the times of other physician services (e.g., colonoscopy). The Cromwell article noted above also discusses this phenomenon and documents that physician time estimates used by CMS are statistically significantly longer than actual documented times in the clinical setting. The AAFP urges CMS to investigate and utilize such extant data sources in its validation of physician time used in establishing RVUs.

While the basic principles of the relative value system have been used to value codes over the past 20 years, newer scientific approaches would allow refinement of estimates of work intensity, just as the RUC has refined other elements of work values. The AAFP asserts that there were initial assumptions underlying the fee schedule regarding work intensity, practice expense and the cost of training that must be reexamined and validated for primary care. The AAFP, along with other specialty societies, has supported research being performed independently at the University of Cincinnati to investigate physician work intensity using more modern techniques. The initial results of that research were [published](#) in "Clinical Work Intensity Among Physician Specialties: How Might We Assess It?: What Do We Find?" in the journal, *Medical Care*. Further results from a subsequent phase of this research are scheduled to be published in the same journal online this fall and in print around the first of the year.

In regards to MedPAC's suggestion of "collecting data on a recurring basis from a cohort of practices and other facilities where physicians and non-physician clinical practitioners work," we note that this is commonly

done for clinical purposes through the AAFP's [National Research Network](#) (NRN) and other practice-based research networks. It may be possible to do the same for purposes of validating elements of physician work and practice expense, as required by the *Affordable Care Act*.

The AAFP supports further the evaluation of "automatic depreciation" of codes which assumes that as new codes and procedures are introduced, they will become more efficient over time which justifies a preprogrammed decrease in value. To maintain the initial value, supplemental data would be required. Currently codes are not subject to an automatic depreciation, since new codes are introduced and very few are brought up for review or decrease in value. Codes would require revalidation of the initial code weight to maintain the code's payment level or the code would automatically be decreased by a certain percentage to be determined by CMS.

II.B.3. Consolidating Reviews of Potentially Misvalued Codes and II.B.4. Proposed Public Nomination Process

In the 2012 proposed rule, CMS states that it believes continuing the annual identification and review of potentially misvalued codes is necessary. Consequently, CMS proposes, for CY 2012 and forward, to consolidate the formal Five-Year Review of Work and Practice Expense with the annual review of potentially misvalued codes.

In conjunction with this proposal, CMS also proposes a process by which the public could submit codes for potential review, along with supporting documentation, on an annual basis. Under the proposed process, CMS would solicit codes for review from the public as part of the comment period on the fee schedule final rule each year. In the subsequent fee schedule proposed rule, CMS would list the nominated codes and then identify which ones will be reviewed as potentially misvalued. CMS would then ask the RUC to review those codes, along with any identified by CMS, and make recommendations back to CMS.

The AAFP remains concerned that CMS continues to rely too heavily on the RUC in this regard. In 2006, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS establish a group of experts, separate from the RUC, to help the agency review relative value units (RVUs). Specifically, MedPAC recommended:

The Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

The AAFP strongly supports MedPAC's recommendation that CMS establish such a group of experts (including consumer and employers), separate from the AMA RUC, to help the agency review and validate RVUs on an ongoing basis. Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and validating RVUs and if supporting evidence was collected and analyzed not only by medical specialty societies but also by experts who were less invested financially in the outcome.

The AAFP supports consolidating the formal Five-Year Review of Work and Practice Expense with the annual review of potentially misvalued codes. We think this will be a more efficient and timely process than dealing with a glut of codes every five years.

We also support providing an opportunity for public nomination of codes as part of this process. However, the timeline for that process is unnecessarily long, and we urge CMS to establish a more rapid review of misvalued services. Under this proposed process, the first opportunity for the public to nominate codes

would be during the public comment period for the calendar year 2012 physician fee schedule final rule. Then, CMS would publish in the calendar year 2013 physician fee schedule proposed rule the list of nominated codes, and whether they will be reviewed as potentially misvalued codes. After that CMS would request that the AMA RUC (or other entities identified by HHS as MedPAC recommends) (review these potentially misvalued codes identified by the public, along with any other codes identified by CMS, and provide recommendations for appropriate physician times, work RVUs, and direct practice expense inputs. Given the usual RUC process, the timeline would appear to gradually unfold as follows:

- November 2011: CMS solicits codes for review in final rule on 2012 fee schedule.
- Summer 2012: CMS lists codes to be reviewed in proposed rule on 2013 fee schedule and refers them to RUC.
- Sept. 2012 - April 2013: RUC reviews codes during meeting cycle and makes recommendations to CMS.
- Summer 2013: CMS publishes its proposed new values in proposed rule on 2014 fee schedule.
- November 2013: CMS publishes final values in final rule on 2014 physician fee schedule.
- January 2014: CMS implements new values.

Thus potentially misvalued services remain misvalued for a full two years after they were identified. The AAFP strongly encourages CMS to work with the RUC and other possible review entities to develop a shortened and streamlined process. Misvalued services need to be more quickly adjusted. For instance, rather than waiting until the next proposed rule to list codes to be reviewed, CMS should share that list with the RUC shortly after the comment period on the final rule, in which the codes are solicited, closes. If CMS and the RUC are unable to develop a more timely process, then CMS should proceed to identify and adjust misvalued codes independently of the RUC.

II.B.5. CY 2012 Identification and Review of Potentially Misvalued Services

In the proposed rule, CMS requests that the RUC conduct a comprehensive review of all evaluation and management (E/M) codes. As the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management of all ages in order to meet the challenges of preventing and managing chronic diseases, CMS believes a more current review of E/M codes is warranted. CMS would like the RUC to prioritize review of the E/M codes and provide CMS with recommendations on the physician times, work RVUs and direct practice expense inputs of at least half of the E/M codes by July 2012 in order for CMS to include any revised valuations for these codes in the calendar year 2013 physician fee schedule final rule with comment period. CMS expects the RUC to review the remaining E/M codes by July 2013 in order for CMS to complete the comprehensive re-evaluation of E/M services and include the revised valuations for these codes in the calendar year 2014 physician fee schedule final rule with comment period.

We appreciate CMS's intention to instigate a comprehensive review of all E/M codes. As we noted in our comments on the proposed rule on the 2011 Medicare physician fee schedule, an effort was made to do this during the third five-year review of the Medicare physician fee schedule. That effort resulted in an increase in the work RVUs of E/M codes in 2007. However, the recommended RVUs for these services reflected a significant compromise on the part of primary care, and due to the statutory requirement for budget neutrality, which CMS chose to apply using a "work adjuster" in that instance, the accepted increase was effectively reduced in a drastic manner.

Accordingly, we are concerned that primary care services in general and E/M services in particular continue to be undervalued. Revising the E/M codes provides an opportunity to recognize and reward high-value primary care services and to encourage integrated models of care such as the patient centered medical

home. Because healthcare reform has consumed so much of our time and other resources during the past two years, the AAFP did not request to CMS that E/M services be part of the current five-year review of the Medicare physician fee schedule. We appreciate that CMS did not take that as an acceptance of the current values for those services, and we are encouraged that the agency has included E/M services in its ongoing efforts to identify, review, and validate potentially misvalued codes.

While we appreciate CMS's desire to conduct a comprehensive review of the relative value of E/M services, we are concerned that CMS has entrusted this review to the RUC under its current structure and function and under the current methodology for valuing services in the fee schedule. In June, the AAFP sent a [letter](#) to the RUC calling upon it to make specific changes in the organization's structure, process and procedures. We believe these changes are important and necessary if the RUC is to remain a credible entity in recommending RVUs to CMS for fee-for-service physician payment determinations for all specialties. We have requested a decision from the RUC regarding the implementation of these changes by March 1, 2012, and we understand that the RUC's Administrative Subcommittee will consider our request at its meeting in September.

We also have concerns about the current methodology for valuing E/M services under the physician fee schedule. For instance, there is a growing amount of data appearing in the literature that suggests the complexity of E/M services provided by primary care physicians today is different and likely more "intense" than the same services provided by other specialties, although the data is limited in that some surveys (e.g. the National Ambulatory Medical Care survey) only allows three diagnoses per visit which is clearly an inappropriate and unrealistic limitation. In addition, the current RUC methodology of using surveys to assess physician work may not adequately account for this variation in complexity since this process is based on the notion of a clinical vignette of the "typical patient" encounter across all specialties. There are likely other data sets besides the RUC survey data which might be revealing in more appropriately valuing all physician services, including those delivered by primary care physicians.

Accordingly, the AAFP has created and funded a [task force](#) to review and recommend to the AAFP Board of Directors alternative methodology(ies) to appropriately value evaluation and management services by family physicians and other primary care physicians. The task force includes experts in health policy and research from within and outside the AAFP, the American College of Physicians, the American Osteopathic Association, the American Academy of Pediatrics, and CMS staff has attended to observe the task force. We will share the report of the task force with CMS when it is available. In the meantime, we believe that it would not be productive to ask the RUC to revalue E/M services under the same structure, procedures, and methodology that it used to establish the current values since, after all, the definition of insanity is doing the same thing over and over again and expecting different results.

Section II.C. Expanding the Multiple Procedure Payment Reduction (MPPR) Policy

Medicare has historically applied a reduction of 50% to the payment amount of second and subsequent procedures provided to the same patient on the same date by the same physician. This reduction, referred to as the "multiple procedure payment reduction" (MPPR), attempts to recognize the efficiencies in practice expense and pre- and post-service physician work that accrue to physicians and their practices when multiple procedures are provided during the same encounter.

In recent years, CMS has extended the MPPR to the technical component of advanced diagnostic imaging services (i.e., CT, MRI, and ultrasound). For 2012, CMS proposes to extend the MPPR to the professional component of such services, too. Beyond 2012, CMS is considering the following additional extensions of the MPPR and invites comments on these possibilities in the proposed rule:

- Apply the MPPR to the technical component of all imaging services, including x-rays

- Apply the MPPR to the professional component of all imaging services
- Apply the MPPR to the technical component of all diagnostic tests (e.g., electrocardiograms, spirometry, etc.)

CMS indicates that any savings resulting from such expansion would be redistributed to other physician fee schedule services as required by the statutory budget neutrality provision.

When CMS extended the MPPR to the technical component of advanced diagnostic imaging services in 2006, we concurred and encouraged CMS's action. We also urged CMS to consider applying a reduction to the professional component in such situations as well. As we noted at the time, just as with the technical component, there are certain efficiencies when a physician is reading images of contiguous areas of the same patient on the same date. For instance, the interpreting physician only has to review the patient's history once to know what he or she is seeking, and often, some portion of the scan is an overlap (i.e., a scan of the pelvis often includes a portion of an abdominal scan). Also, usually there is only one dictation for the multiple scans. Accordingly, there is less physician work involved than would be the case if the scans were interpreted independently at different points in time. Consequently, we support CMS's current proposal to extend the MPPR to the professional component of advanced diagnostic imaging services (i.e., CT, MRI, and ultrasound) beginning in 2012.

In regards to additional expansions under consideration, we see no reason why the same principles should not apply to the professional and technical component of all imaging services. What is less clear is whether the same principle can be applied to the technical component of all (non-imaging) diagnostic tests. For instance, it is not clear to us that the efficiencies that accrue when multiple x-rays are taken at the same encounter are present when an x-ray and electrocardiogram are done at the same encounter, and if there are efficiencies in the latter scenario, we are not comfortable that they are equivalent (i.e., 50%). Therefore, we would encourage further study and discussion before CMS considers any proposal to extend the MPPR to the technical component of all diagnostic tests.

Section II. E. Geographical Practice Cost Indices

CMS is required to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three components (physician work, practice expense, and malpractice) of the fee schedule. The agency must review and adjust as necessary the GPCIs at least every 3 years. Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. Beginning January 1, 2011, Congress set a permanent 1.0 practice expense GPCI floor for services furnished in "frontier states" (i.e., at least 50 percent of the state's counties have a population density of less than 6 persons per square mile). CMS identified five frontier states (Montana, Wyoming, North Dakota, Nevada and South Dakota). For other states, the current 1.0 physician work floor will expire at the end of 2011 unless Congress intervenes before 2012. CMS last updated the physician work GPCI in 2011 based on 2006-2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics data.

CMS is not proposing to make further revisions in 2012 to the work GPCI, though the agency notes the work GPCIs as published reflect the expiration of the statutory work floor. The AAFP will continue to work with Congress to insure the work GPCI issue is addressed and encourages CMS to propose to Congress that they should maintain the work GPCI floor, or even provide a payment boost, in areas designated as Medically Underserved Areas/Populations and Health Professional Shortage Areas.

Regarding the 2012 practice expense data sources, CMS proposes to:

- Revise the occupations used to calculate the employee wage component of practice expense using wage data from the federal Bureau of Labor Statistics specific to the office of physicians' industry;

- Utilize two bedroom rental data from the 2006-2008 American Community Survey as the proxy for physician office rent;
- Create a purchased service index that accounts for regional variation in labor input costs for contracted services from industries comprising the "all other services" category within the Medicare Economic Index (MEI) office expense; and
- Use the 2006-based MEI (most recent MEI weights finalized in the 2011 final rule) to determine the GPCI cost share weights.

The AAFP concurs with the proposal to use MEI data to determine GPCI cost share weights and we support the proposal to create a purchased service index that accounts for regional variation in labor input costs for contracted services from industries comprising the "all other services" category within the Medicare Economic Index (MEI) office expense. Likewise the AAFP commends the proposal to revise the occupations used to calculate the employee wage component of practice expense using wage data from the federal Bureau of Labor Statistics specific to the office of physicians' industry.

However, we have concerns over the other proposed practice expense GPCI changes. While we appreciate CMS's attempt to achieve maximum accuracy of the data or proxies, the AAFP cautions CMS not to focus on this aspect to the exclusion of the effects payment policy has on physicians' decisions on where to establish their practices. The AAFP believes the proposed changes work against CMS' interest in improving physician distribution and increasing access for beneficiaries in rural and underserved areas and we believe the focus on cost precision ignores the bigger problem of how to incentivize practice location where needed. CMS should, at the very least, wait for the Institute of Medicine to finish its study on GPCI values before prematurely finalizing these proposed changes.

The malpractice GPCIs are calculated based on insurer rate filings of premium data for \$1 million to \$3 million mature "claims-made" policies. Based on the data analyzed, CMS proposes to revise the cost share weight for the malpractice GPCI from 3.865 percent to 4.295 percent. The AAFP concurs with this change as it is more representative of reality.

Section III. Medicare Telehealth Services for the Physician Fee Schedule

Over the past year, CMS has received requests to add the following as newly covered Medicare telehealth services: smoking cessation, critical care, domiciliary or rest home E/M services, genetic counseling, online E/M services, data collection, and audiology. In response to these requests, CMS proposes to add only the following to the list of telehealth services for 2012:

- CPT code 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes)
- CPT code 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes)
- HCPCS code G0436 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes)
- HCPCS code G0437 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes)

Additionally, CMS proposes to refine its category 2 review criteria for adding codes to the list of Medicare telehealth services beginning in 2013 by modifying the current requirement to demonstrate similar diagnostic findings or therapeutic interventions with respect to a candidate service delivered through telehealth compared to in-person delivery of the service. Specifically, CMS proposes to establish a revised standard of demonstrated clinical benefit when the service is furnished via telehealth as follows:

Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests would include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. Requestors should submit evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient.

The evidence submitted should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings and a list and copies of published peer-reviewed articles relevant to the service when furnished via telehealth. Some examples of clinical benefit include the following:

- *Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.*
- *Treatment option for a patient population without access to clinically appropriate in-person treatment options.*
- *Reduced rate of complications.*
- *Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).*
- *Decreased number of future hospitalizations or physician visits.*
- *More rapid beneficial resolution of the disease process treatment.*
- *Decreased pain, bleeding, or other quantifiable symptom.*
- *Reduced recovery time.*

We support CMS's decision to add smoking cessation services to the list of approved telehealth services. We also support CMS's proposal to revise its category 2 criteria from a comparability standard to a clinical benefit standard. As CMS notes in the proposed rule, the agency has never added any services to the telehealth list under the current category 2 standard. The modified standard should represent a more reasonable one to those nominating services for the list.

By creating ready access to information, telemedicine can provide physicians with current medical information that may not otherwise be available in a given setting. The AAFP believes that 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. The revised category 2 criteria, as a clinical benefit standard, come closer to the AAFP's position in this regard.

Section IV. E.1 Incorporation of a Health Risk Assessment as Part of the Annual Wellness Visit

The Affordable Care Act expanded the preventive care benefits available to Medicare Part B beneficiaries. In addition to the existing "Welcome to Medicare" visit (also known as the Initial Preventive Physical Exam or IPPE) for new Medicare Part B beneficiaries, as of 2011 Medicare now also covers an Annual Wellness Visit (AWV) for personal prevention plan services.

The ACA specifies that a personalized prevention plan for an individual includes a health risk assessment (HRA) that meets the guidelines established by CMS. In general, an HRA is an evaluation tool designed to provide a systematic approach to obtaining accurate information about the patient's health status, injury risks, modifiable risk factors, and urgent health needs. The information from the HRA is reflected in the personalized prevention plan that is created for the individual.

CMS proposes to add the term "health risk assessment" and its definition into revised definitions of "first annual wellness visit providing personalized prevention plan services" and "subsequent annual wellness visit providing personalized prevention plan services", and incorporate the use and results of an HRA into the provision of personalized prevention plan services during the AWV. While the AAFP supports the concept of the HRA, we cannot support CMS' proposal to add a required health risk assessment (HRA) to the annual wellness visits (AWV) provided in 2012 for the following reasons:

- The *Affordable Care Act* requirement for an HRA as a component of the AWV is connected with other requirements of Section 4103 that have not been completed and directly impact the ability of physicians to implement Section 4103 (1)(A).
- CMS ties the implementation of the health risk assessment to an unpublished CDC guidance document.
- No publicly available HRAs have been identified.
- The burden of creating, implementing, and adding elements to the HRA is significant and cannot be provided at the Level IV office visit rates.

Section 4103(1)(A) of the *Affordable Care Act* includes provisions requiring the inclusion of a HRA in the AWV, and section 4103(4)(A) requires the adoption of publicly available guidelines for HRAs, but the provisions further state that, "Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A)." While we understand CMS's desire to comply with the inclusion of the HRA into the AWV, it is unfair to hold physicians accountable for this portion of the *Affordable Care Act* when the Secretary has not yet fulfilled the crucial step of providing an HRA model.

The Morbidity and Mortality Weekly Report (MMWR) that will be published by the Centers for Disease Control and Prevention to provide physicians with additional information applicable for the successful implementation of the HRA may impact development of the HRA and processes for delivering it. How can physicians successfully implement an HRA in January of 2012 when no model and no guidance are available?

CMS requests feedback regarding the availability of HRAs that are available for use by the general public. The AAFP researched HRAs discussed in the AHRQ technology assessment and none meet the proposed CMS criteria. Most are specific to one health condition or are designed for non-Medicare patient populations and nearly all are proprietary and not publicly available. The AAFP is not aware of any available HRAs and we do not believe that any HRA would meet the specific guidance of the CDC was included in the technology assessment performed by the Agency for Healthcare Research and Quality (AHRQ).

In addition to considerations of whether there are publicly available HRAs, it is important to consider the differences between HRAs administered by private health plans (and the vendors hired by such plans to provide HRA services) from the resources available to physicians. No funding exists for physicians in private practice to hire a vendor to design, deliver, and interpret HRAs. The implementation of HRAs as part of the AWV must take into account not only the limited resources of the physician practice but also factors such as internet usage by the Medicare population as noted in the AHRQ technology assessment. According to the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) [data brief](#) from July 2011, only 25% of persons 65 and older used the internet for health information. Pew Internet [research](#) indicates that only 46% of persons over 65 use the internet at all. The Federal Communications Commission [reports](#) that 42 percent of Americans with disabilities have broadband at home. Completion of an online HRA including the recommended elements will require a reliable internet connection and familiarity with internet use. It is likely that the majority of HRAs in the current Medicare population will be delivered by a phone call

from physician office staff or in person at the time of the AWV. This will add a significant burden of time and expense for the practice.

As noted above, the AAFP does not feel that CMS is correct in their assessment that the AWV including the HRA as defined in the proposed rule would continue to be most accurately equivalent to a level 4 E/M new or established patient visit. CMS states that this crosswalk is appropriate because the services described by CPT codes 99204 and 99214 already include 'preventive assessment' forms. However, preventive assessment forms valued in 99204 and 99214 would not be the comprehensive assessment forms required for the AWV with HRA.

To add the elements necessary for documentation of the AWV as defined by CMS in 2011, the AAFP through its Family Practice Management magazine redesigned a 2-page form developed to capture the elements of the Initial Preventive Physical Exam (IPPE) into a [6-page form](#) to capture the additional elements of the AWVs as defined by CMS in 2011 and the additional covered Medicare preventive services. The inclusion of an HRA developed based on the CDC guidance and CMS' proposed elements will reach another level of complexity.

We also note the CDC guidance includes questions and topics to be addressed as deemed appropriate for the beneficiary's age. It is also necessary to tailor the HRA to the average age, cultural values, general education levels, and other socioeconomic factors of the Medicare population served by a physician practice. CMS proposes to require the same questions for all Medicare beneficiaries. As the AAFP noted in comments to the CDC request for comments on the development of HRA guidelines, "It would be helpful to have explicit guidance from the CDC and CMS about acceptable alternative formats and content for HRAs for various patient groups or populations." It is clear that the AHRQ and CDC have exerted considerable time and effort in the technology assessment and draft guidance. However, this work must be advanced to include the development of publicly available HRA models certified and formally accepted by CMS for fulfillment of the Section 4103 (1) (A) requirement to include an HRA in the AWV.

Section IV.F. Quality Reporting Initiatives

The Physician Quality Reporting System (PQRS) provides incentive payments and payment penalties to identified eligible professionals who satisfactorily report (via Medicare Part B claims, qualified PQRS registry, or qualified PQRS electronic health record (EHR)), data on quality measures for covered professional services furnished during a specified reporting period (full and half year options).

F.1.b(C). Proposed changes to group practices

For purposes of the PQRS Group Practice Reporting Option (GPRO) II, CMS had defined "group practice" as "a single Tax Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Number (NPI), who have reassigned their Medicare billing rights to the TIN." In the proposed regulation, CMS discusses that many smaller group practices that self-nominated to participate in the GPRO II in 2011 eventually elected to opt out so that members of the group practice could instead participate in the PQRS individually. Citing this reason, CMS proposes to change the GPRO II definition as a TIN with 25 or more individual eligible professionals who have reassigned their billing rights to the TIN. CMS also proposes to consolidate the GPRO I (designed for TINs with more than 200 NPIs) and GPRO II into a single GPRO.

The vast majority of medical groups have less than 25 physicians, therefore the AAFP is concerned that the proposed PQRS GPRO reporting option will exclude small to medium sized practices. Just because a few medical groups that initially opted to participate via the GPRO II eventually decided to report through alternative mechanisms, does not mean that CMS should entirely abandon a group practice reporting option

for medical groups with less than 25 physicians. Given that the PQRS payment penalties begin in only a few years, the AAFP believes participation in the PQRS will likely increase. Therefore the AAFP recommends that CMS continue offering as many reporting options as possible to facilitate successful participation by small to medium sized group practices.

CMS further proposes that group practices selected to participate in the 2012 PQRS would be required to report on 40 proposed measures listed in Table 56 of the draft rule. CMS proposes to retain most of the measures available under the 2011 PQRS GPRO because of their continued interest in those measures and to maintain program consistency. However, CMS proposes to retire three measures that were required under the 2010 and 2011 GPRO and to add eighteen measures to the PQRS GPRO.

Although CMS makes no proposals at this time, the agency invites public comment on possibly expanding the definition of group practice for PQRS purposes to be comprised of multiple TINs. As a way to address the need for small and medium sized group practices to participate in the GPRO, the AAFP recommends CMS consider allowing virtual groups to form for purposes of the PQRS. If a several TINs wish to partner together to participate in the PQRS, CMS should allow this entity to participate in the PQRS GPRO.

F.1.c. Proposed reporting periods

For the 2012 PQRS, CMS proposes a 12-month reporting period for the satisfactory reporting of PQRS quality measures for claims-, registry-, and EHR- based reporting by individual eligible professionals as well as a 12-month reporting period for the PQRS Group Practice Reporting Option (GPRO). This proposal eliminates the 6-month reporting period for claims- and registry- based participation previously available under the PQRS. CMS justifies this by noting that the 12-month reporting period aligns with other CMS quality reporting programs.

The AAFP agrees that a 12-month reporting period aligns with other programs, but urges CMS to nonetheless continue offering a 6-month PQRS reporting option. CMS originally offered the 6-month reporting period as a way to gradually attract eligible professionals that are unfamiliar with the PQRS into the program. Since PQRS participation and success rates continue to be modest, the AAFP urges CMS to continue the half year reporting option as a way to continue attracting new PQRS participation.

F.1.d.2(B). Registry-based reporting

CMS intends to publish the final 2012 PQRS registry requirements online in mid-November 2011. CMS does not expect to complete the vetting process for the new 2012 data submission requirements until mid-2012. The AAFP believes this timeframe is unacceptable and we urge the agency to significantly accelerate the requirement definition and review process for qualifying PQRS registries so that physicians are not informed of their registry options halfway through the reporting period for 2012. Unless the vetting process is expedited, the benefits of the registry- and EHR- based reporting methods will not be available to a majority of eligible professionals impacted by the PQRS.

In an effort to improve the accuracy of data collected by PQRS registries, CMS discusses the possibility that in years after 2012, the agency may require registries to submit all collected data elements for CMS to calculate an eligible professional's reporting and performance rates. In this proposed rule, CMS emphasizes the submission of patient-level data, rather than the current reporting of aggregate data on Medicare beneficiaries. The AAFP believes the reporting of "patient-level" data is a completely different philosophy and practice than the reporting of "population-level" measures. Data quality should be an integral part of the data collection, analysis and submission processes. However, requiring the submission of all data collected does nothing to improve its accuracy or validity. Deeper issues including the insufficient electronic description and logic expression of existing performance measures need to be fully addressed regarding the

inaccuracy of submitted measure calculations by external systems. Individual eligible professionals must be provided access to tools and processes to measure and improve their own performance, not only on marginally “standardized” measures, but on diagnosis, treatment and operations issues that are of specific interest to them. A “black box” at CMS will not adequately serve a “learning health care system”.

F.1.d.3. EHR-Based reporting

For 2012 and beyond, CMS proposes that eligible professionals who choose to participate in the PQRS via the EHR-Based reporting mechanism have the option of submitting quality measure data obtained from their PQRS qualified EHR to CMS either directly from a qualified EHR or indirectly from a qualified EHR data submission vendor (on the eligible professional’s behalf).

CMS then discusses separate vetting processes for qualifying “direct” and “indirect” EHR systems for purposes of the PQRS. These vetting processes will result in the agency announcing qualified EHR systems midway through 2012. The AAFP finds this unacceptable and urges CMS to drastically accelerate the review process in order to encourage participation in the PQRS through EHR-based reporting.

CMS proposes several requirements vendors must meet to qualify as a PQRS EHR vendor. One requirement is that the vendor must “be able to collect all needed data elements and transmit to CMS the data at the beneficiary level.” The AAFP urges CMS to more fully define the terms “all needed data elements” and “beneficiary level”. These definitions must not become an insurmountable barrier for family physicians and their healthcare teams.

Another proposed requirement for PQRS EHR vendors is to be able to transmit data in a CMS-approved XML format utilizing a Clinical Document Architecture (CDA) standard such as Quality Reporting Data Architecture (QRDA). The submission file specifications are not delineated except for a vague suggestion that a pilot project of HL7 (QRDA) be the standard defined in regulation. This specification has not been proven broadly implementable or even fit for purpose. The AAFP urges CMS to avoid placing arbitrary limitations on the data set and transmission specifications, particularly before evidence of successful reference implementations have been established. The HHS Office of National Coordinator requested comment on QRDA in the past and opted against it due to these issues. Though HL7 Version 2.X messaging is commonly used in healthcare, the HL7 CDA specification has been far less successful in its adoption. Other technical options should not be excluded at this early stage in the process. Though XML is a ubiquitous format for data expression, many other formats are currently available. The AAFP urges CMS to consider options that may be less complex and costly to implement and maintain.

After discussing the PQRS EHR vendor requirements and lengthy vetting processes, CMS then states that the agency cannot assume responsibility for the successful submission of data from eligible professionals’ EHRs. If CMS is to “qualify” third party systems to submit data for the PQRS and electronic prescribing programs, then the AAFP believes the agency must take some level of responsibility and hold vendors accountable for successful data submission on behalf of eligible professionals.

F.1.f. Proposed 2012 PQRS measures

CMS proposes to retain all measures (55 registry-only measures and 144 individual quality measures for either claims-based reporting or registry-based reporting) currently used in the 2011 PQRS. CMS proposes 26 new individual measures for inclusion in the 2012 PQRS. Of these measures, 13 would be reportable via registry-only. The remaining 13 measures would be available for claims and registry reporting. For 2012, CMS proposes that any 2012 PQRS measure included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting. In order to better align PQRS measures with those under the Medicare EHR Incentive Program, for 2012 CMS

proposes to have 44 clinical quality measures in the Medicare EHR Incentive Program available for EHR-based reporting under the 2012 PQRS. CMS proposes to retain 14 of the 2011 PQRS measures groups for the 2012 PQRS and add 10 new PQRS measures groups for the 2012 PQRS.

F.1.f.3(A). Proposed 2012 Physician Quality Reporting System Core Measures

In the 2012 proposed Medicare physician fee schedule, CMS discusses the need to promote the prevention of cardiovascular conditions. As such, CMS proposed seven PQRS core measures in Table 29 that are aimed at promoting the prevention of cardiovascular conditions. CMS proposes that “eligible professionals specializing in internal medicine, family practice, general practice, or cardiology” be required to report on at least one proposed PQRS core measure (via claims-, registries-, or EHR- based methods) in addition to reporting on at least two additional measures that apply to the services furnished by the professional. They must report each measure for at least 50 percent of the eligible professional’s Medicare Part B fee for service patients for whom services were furnished during the reporting period to which the measure applies.

Forcing specific physician specialties to report on a subset of PQRS measures is uncharted waters; however the AAFP acknowledges CMS’s point on the importance of promoting the prevention of cardiovascular conditions. Nevertheless, the AAFP is concerned that family physicians that are already experienced with participating in the PQRS by reporting on non-cardiovascular measures will be subjected to further PQRS administrative hassles since they will be forced to modify existing systems and processes in order to capture clinical information necessary for reporting on a cardiovascular measure.

The AAFP is also concerned that two of the proposed PQRS core measures lack endorsement from the National Quality Forum (NQF). It is the AAFP’s position that all measures must eventually be endorsed by the NQF using the measure criteria and following the normal consensus development process used by the NQF. We note that the “preventative care: cholesterol- LDL test preferred” and “proportion of adults 18 years and older who have had their blood pressure measure within the preceding 2 years” measures are merely process measures instead of outcomes measures which are more favorable from a quality improvement perspective.

In a separate PQRS section focusing on reporting through EHRs, CMS discusses a proposal that would require physicians specializing in “internal medicine, family practice, general practice and cardiology” that are participating in the PQRS via an EHR-qualified system to report on all seven PQRS core measures. In this discussion, CMS assumes this proposal “would not add an additional burden to these eligible professionals because the reporting of measures is done entirely through the EHR.” The AAFP disagrees with this assumption, and we believe that reporting through the EHR does not equalize the burden of reporting via claims-based reporting on three measures. CMS should not assume that current EHR systems “automatically” capture and calculate quality measures as most systems require a significant number of additional steps to successfully capture and report quality data. All data collection methods also require time and energy to validate and correct errors.

F.1.g. PQRS Maintenance of Certification Program Incentive

The Affordable Care Act calls for an additional 0.5 percent PQRS incentive payment for individual professionals who participate via a “continuous assessment program.” CMS proposes that to earn this additional 0.5 percent in 2012, in addition to meeting the proposed requirements for satisfactory reporting for the PQRS for a program year, the eligible professional must have data with respect to the eligible professional’s participation in a Maintenance of Certification (MOC) program submitted by a qualified medical specialty board or other entity sponsoring a MOC program. As an alternative, the provider may satisfactorily report under the PQRS based on submission of PQRS data by a (MOC) program that is qualified as a PQRS registry for 2012.

The qualified medical specialty board or other entity sponsoring a MOC program must submit data to CMS certifying that the eligible professional “more frequently than is required” qualified for or maintained board certification. CMS does not propose to specify how a physician must meet the “more frequently” requirement, but rather that the MOC program determine what a physician must do. CMS proposes, as a basic requirement, successful completion in at least one MOC program practice assessment for each year the physician participates in the MOC program incentive, regardless of whether or how often the physician is required to participate in a MOC program to maintain board certification.

Since 1965, the AAFP has both accredited and provided extensive continuing medical education (CME) activities and resources for family physicians and other health care professionals. That CME is designed to support physicians' lifelong learning and continuous improvement in professional competence, practice performance, and patient outcomes, as well as to demonstrate fulfillment of their professional requirements for continuing professional development, licensure, and board certification. We concur with the proposal for the maintenance of certification board to provide information to CMS on the applicable eligible professionals.

F.1.h. PQRS feedback reports and F.1.i. Informal Review Process

Section 1848 of the *Affordable Care Act* requires CMS to provide timely feedback to PQRS participants. Typically, CMS issues PQRS feedback reports and incentive payments around July of the year following the reporting period. CMS proposes to continue issuing feedback reports for 2012 and beyond around the same time incentive payments are issued. CMS proposes to provide interim feedback reports in the summer of the respective program year to eligible professionals that are reporting individual measures and measures groups through the claims- based reporting.

While the interim feedback reports could be helpful, the AAFP has concerns with the proposal to continue issuing PQRS feedback reports only at the same time incentive payments are made. The current 18-24 month lag time between the point of care and access to a feedback report is fundamentally not helpful from a quality improvement perspective. If the PQRS program is truly intended to improve the quality of physician services, the AAFP believes CMS must begin offering timelier (monthly or quarterly) interim feedback reports to PQRS participants. Ideally, this could take the form of a twelve month rolling average of performance levels, calculated and reported monthly.

The 2011 PQRS informal appeals process allows eligible professionals to contact the Quality Net help desk (via phone or e-mail) to request an informal review. Quality Net must respond to this request within 60 days of receiving the original request. Citing an anticipated growth in volume of informal review requests, CMS proposes to allow a 90 day informal review response time. The AAFP believes the proposal to give the Quality Net help desk even more time to respond to PQRS inquiries is a step in the wrong direction. The AAFP reminds CMS that the current 60-day informal review response time does not necessarily mean that the informal appeals process is concluded in that timeframe. In fact, a simple response from Quality Net may be insufficient for the physician applying for an appeal, but the physician might still need to make a second request and restart that 60-day clock. Instead, CMS and its contractors should be required to provide more timely and accurate responses especially if a growth in volume is anticipated.

F.1.j. 2015 PQRS penalty based on 2013 PQRS reporting

Beginning in 2015, a payment penalty will apply under the PQRS. Specifically, if the eligible professional does not satisfactorily participate in the PQRS, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. The applicable percent is:

- 98.5 percent for 2015; and

- 98.0 percent for 2016 and each subsequent year.

CMS proposes a 12-month reporting period for the 2015 payment penalty and proposes that the reporting period for purposes of the 2015 payment penalty be the 2013 calendar year. The AAFP recognizes that it takes considerable amounts of time and resources for CMS to calculate payment penalties on a prospective basis. However we believe the congressional intent of the PQRS payment penalty was to stimulate participation during the payment penalty year. As such the AAFP opposes the proposal to base the 2015 PQRS penalty using 2013 performance. CMS's inability to analyze data in a timely manner is leveraging a significant penalty on non-exempt eligible professionals. We believe this CMS proposal further illustrates the long lag time in CMS's ability to calculate PQRS success and create feedback reports. The reports would not represent the current status of the reporting entities and therefore would be less effective in leveraging change.

Section IV.F.2. Incentives and Payment Adjustments for Electronic Prescribing (eRx)

In this proposed rule, CMS sets forth proposals for the 2012, 2013, and 2014 electronic prescribing reporting periods. For years 2012 through 2014, CMS will apply a payment penalty to eligible professionals who are not successfully electronic prescribing. The applicable eRx percent for payment incentives and penalties under the eRx Incentive Program are set in statute and are as follows:

- 2011: 1.0 percent for successful electronic prescribers.
- 2012: 1.0 percent for successful electronic prescribers or -1.0 percent for non-successful electronic prescribers.
- 2013: 0.5 percent for successful electronic prescribers or -1.5 percent for non-successful electronic prescribers.
- 2014: -2.0 percent for non-successful electronic prescribers.

CMS discusses that no eRx incentive payments or penalties are authorized beyond 2014. While the AAFP appreciates the "expiration" of the payment penalty, we urge CMS and Congress to not seek to reinstate the penalty as it would constitute a double jeopardy in conjunction with the penalties associated with the Medicare and Medicaid EHR programs.

For purposes of the incentive payment and the payment penalties, CMS proposes to determine success at the NPI level. CMS proposes to modify the eRx group practice reporting option to align with their proposed definition of group practice for purposes of the 2012 PQRS (that is, TINs with at least 25 NPIs). Similar to comments made on the PQRS GPRO proposals, the AAFP has similar concerns with this proposal and believes CMS should continue offering the eRx group practice reporting option to small to medium sized practices.

CMS also proposes to modify the Part D electronic prescribing standards required for a "qualified" electronic prescribing system under the eRx Incentive Program to have these standards consistent with current, CMS Part D electronic prescribing standards. The AAFP concurs with this effort.

CMS considered using Part D data to determine successful prescribing under the eRx Incentive Program though ultimately the agency believes the use of Part D prescriptions for analysis may be premature citing that Part D data is fairly new. The Part D program went into effect in 2006 therefore the agency in 2012 will possess over five years of data. The inability of CMS to leverage Part D data to satisfy reporting requirements for the eRx incentive program does not evoke confidence in eligible professionals that the agency has the infrastructure to effectively manage the data they are requiring eligible professionals to submit for this and other programs. As the fourth year of the eRx incentive program approaches, it is remarkable how accurate and actionable formulary data and cost effective therapeutic alternative information is still significantly lacking. The AAFP interprets this as an indicator of the sluggish pace of

innovation in the HIT market. Therefore the AAFP urges CMS to refocus efforts on the use of Part D data for purposes of determining successful participation in the eRx program.

Section IV.G. Physician Compare Web Site

As required by section 10331 of the *Affordable Care Act*, CMS has developed a Physician Compare [web site](#). In its first phase, this web site displays information on physicians enrolled in the Medicare program with an indication of those that satisfactorily submitted quality data for the 2009 Physician Quality Reporting System (PQRS).

Section 10331 further requires that, no later than January 1, 2013, CMS implement a plan for making information on physician performance publicly available through the Physician Compare Website. To the extent that scientifically sound measures are developed and are available, CMS is required to include:

- Measures collected under the PQRS;
- An assessment of patient health outcomes and functional status of patients;
- An assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;
- An assessment of efficiency;
- An assessment of patient experience and patient, caregiver, and family engagement;
- An assessment of the safety, effectiveness, and timeliness of care; and
- Other information as determined appropriate by CMS.

Toward this end, CMS proposes to make public the performance rates of the quality measures that group practices submit under the 2012 PQRS group practice reporting option (GPRO). The AAFP is comfortable with this initial approach. CMS proposes that group practices participating in the 2012 PQRS GPRO would agree in advance to have their performance results publicly reported as part of their self-nomination. CMS also proposes to publicly report the performance rates of the quality measures that the group practices participating in the Physician Group Practice demonstration report on the Physician Compare Web site as early as 2013 for performance information collected in 2012. To eliminate the risk of calculating performance rates based on a small denominator, CMS proposes to set a minimum patient sample size of 25 patients, which will have to be met in order for the group practice's measure performance rate to be reported on the Physician Compare website. CMS proposes to identify the individual eligible professionals who were associated with the group during the reporting period by posting a list of the eligible professionals on the Physician Compare website. However, the information on measure performance would apply to the group as a whole, rather than to individual physicians within a group.

As stated in our guiding principles for physician performance reporting, the AAFP believes the primary purpose of performance measurement and sharing the results should be to identify opportunities to improve patient care. To accurately compare physicians, CMS must use consistent and standardized metrics widely used and accepted by physicians and comparable to metrics used by other health payers. The AAFP is thus concerned that CMS is prematurely creating a physician compare website when standardized metrics for items like assessment of safety, effectiveness and timeliness of care, and assessment of continuity and coordination of care do not yet exist. Payers' physician measurement programs should lead to better informed physicians and/or consumers and align with existing relevant AAFP [policies](#) on Physician Profiling Principles and Performance Measures. The benefit of measurement is reporting the results, so the improvement process can begin and be measured over time. Ideally, any Physician Performance Reporting should:

- Support the physician/patient relationship.
- Provide physician performance reports/ratings to assessed physician within meaningful time periods and be compared against both peers and performance targets prior to being made public.

- Be transparent in all facets of physician measurement analysis, including:
 - Origin and definitions of data sources
 - Number of cases assessed per measure
 - Performance measures utilized and their source
 - Margin of error assumed in calculations
 - Basis of evaluation - the individual physician or physician group level
 - Clear communication of the validity, accuracy, reliability and limitations of data utilized, which may include:
 - Defining the peer group against which individual physician performance is being measured/compared;
 - Detailing steps taken to ensure data accuracy and disclose 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;
 - Describing the assignment of patient populations to either individual or physician groupings;
 - Including appropriate risk adjustment and case mix measures; and
 - Using meaningful time periods for data comparisons.
- Identify physicians that meet quality standards separately from their cost assessment
- Utilize appropriate and easy to understand designations for physicians who:
 - Have statistically insufficient data to assess physician performance;
 - Have data currently under review with pending results;
 - Have declined to display their designation;
 - Have insufficient claims data with the payer for evaluation;
 - Practice in a specialty that is not evaluated under the program;
 - Practice in a market where the payer's program is not available; or
 - Have not met payers' criteria for a designation.
- Provide a minimum of 90 days for physicians to review, validate, and appeal their payer's performance report before public reporting.
- Immediately adjust physicians' performance rating/designation(s) based upon a successful reconsideration or discovery of errors in the payer's data analysis.
- Provide consumers adequate guidance about how to use the physician performance information and explicitly describe any limitations in the data.

The AAFP reminds CMS that the *Affordable Care Act* stipulates that public reporting should only occur to the extent that scientifically sound measures are developed and available. The AAFP views physician quality reporting as still an emergent field, lacking scientific, sound measures. Reporting raises issues of patient attribution, statistical validity, significant risk of error from the use of claims data and problems adjusting for patient populations. The AAFP urges CMS to be aware of the possibility of penalizing physicians who see patients who are less willing or able to adhere to recommended care. Finally the AAFP cautions CMS that public reporting can have unintentional adverse consequences for patients if, for example, patient de-selection occurs for individuals at higher risk of illness due to age, diagnosis, economic or cultural characteristics, etc.

Section IV.H. Medicare Electronic Health Record Incentive Program for the 2012 Payment Year

The *American Recovery and Reinvestment Act of 2009 (ARRA)* provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals participating in the Medicare and Medicaid programs that successfully adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology. In this 2012 fee schedule, CMS proposes that:

- For the 2012 payment year, eligible professionals may continue to report clinical quality measure results as calculated by certified EHR technology by attestation.

- The agency initiate a “Physician Quality Reporting System-Medicare EHR Incentive Pilot” to allow eligible professionals on a voluntary basis to participate in the Medicare EHR Incentive Program and meet the clinical quality measures reporting requirements of the EHR Incentive Program for payment year 2012 by submitting quality measure information electronically.

CMS stated in the 2011 final rule that certified EHR technology will be required to calculate the clinical quality measure results and transmit under the PQRS Registry XML specification, but CMS subsequently determined that it is not feasible to receive electronically the information necessary for clinical quality measure reporting based solely on the use of PQRI 2009 Registry XML Specification content exchange standard as is required for certified EHR technology. The agency explains this is because the specification is tailored to the elements required for 2009 PQRI Registry submission, rather than constituting a more generic standard. As a result, CMS proposes to modify the requirement that clinical quality measure reporting must be done electronically and propose that for the 2012 payment year, eligible professionals may continue to report clinical quality measure results as calculated by certified EHR technology by attestation as was done in 2011. The AAFP is not surprised that the PQRI 2009 Registry XML Specification is not suitable for quality measure reporting (and commented as such in a March 2010 comment letter). The AAFP cautions that the Clinical Document Architecture (CDA) and its Quality Reporting Data Architecture “template” (QRDA) are equally ill equipped at this time.

The AAFP believes the “Physician Quality Reporting System-Medicare EHR Incentive Pilot” is unlikely to draw a significant number of volunteers. A majority of participants will likely be recruited by EHR vendors. As such, these “volunteers” do not compare well with the average eligible professional who would be subjected to the biased assumptions of the pilot in the future.

The AAFP believes many EHR vendors have poorly implemented the meaningful use sanctioned quality measures in their “certified” EHR systems. The expectation that these same vendors will effectively and efficiently implement PQRS measures and report them in Quality Reporting Data Architecture at the patient-level is, at best, overly optimistic.

As part of the proposed EHR-Based reporting option under the PQRS-Medicare EHR Incentive Pilot, CMS proposes to require the submission of “patient-level” data to enable CMS to employ a “uniform calculation process”. The AAFP finds this to be exceptionally near-sighted. The failure of the measure developer and endorser community to develop a reliably computable format for measure expression is not an acceptable outcome. Eligible professionals must be empowered with the technology to measure and improve their own quality. Centralizing all provider quality assessment within CMS would fundamentally be objected by family physicians and as such the AAFP urges CMS to reconsider this proposal.

Section IV.I. Improvements to the Physician Feedback Program and Establishment of the Value-Based Payment Modifier

3.a. Future Considerations for Phase III Physician Feedback Reports

Sections 3003 and 3007 of the *Affordable Care Act* call for CMS to improve the existing physician feedback pilot program (Phase I and II already completed) and establish a value-based payment modifier. CMS discusses how these sections mutually reinforce their goal to provide physicians with fair, actionable and meaningful information concerning resource use and quality. CMS anticipates that the physician feedback reports will serve as the testing basis to develop and implement the value modifier, which will be applied to certain physicians and physician groups under the physician fee schedule starting in 2015. CMS is required to establish by 2012 the quality measures for the value modifier. CMS is also required to specify an initial performance period for the application of the value modifier with respect to 2015.

In the 2012 proposed fee schedule, CMS proposes to increase production and dissemination of Physician Feedback reports when it starts Phase III.

To satisfy the requirement that CMS establish the quality measures used for the value modifier by 2012, CMS proposes to use information from:

- The PQRS core measures on cardiovascular conditions for 2012;
- All measures in the GPRO of the PQRS for 2012; and
- The core measures, alternate core, and 38 additional measures in the 2012 Medicare EHR Incentive Program.

To satisfy the CMS requirement to specify an initial performance period for the application of the value modifier with respect to 2015, CMS proposes the initial performance period be the calendar year 2013.

The AAFP is concerned that CMS is prematurely scaling up efforts with Phase III when underlying problems with Phase I and II reports have not been satisfactorily addressed. We also are concerned with using 2013 as the performance year since clinical quality measures are not yet fully understood and practices deserve at least a year's worth of data before payment penalties are linked to performance. Similar to our comments on the delayed PQRS feedback reports, the AAFP believes that *more timely access* to resource use feedback reports will provide physicians with feedback that is more actionable; merely providing more reports that are not timely or actionable does not provide a service that is helpful for physicians, the patients they treat, or the Medicare program. Using 2013 as an initial performance period is too soon and nothing in the ACA requires that the initial performance period be based on a calendar year or that the performance period cover an entire 12 months. The AAFP believes that CMS should not rush implementation of the value-based payment modifier and hastily adjust physicians' Medicare payments based on their performances executed during a time when the physicians do not know what the payment policies would be. Instead CMS should collect the necessary data for a statistically relevant period beginning the day of the performance year. Physicians must have a specific period in which the criteria against which they will be measured are in effect before the value-based modifier is used. As part of this, CMS must publically develop further specifications surrounding this program while significantly improving the agency's capability of processing Medicare claims and performance data in a more meaningful and real-time manner.

4.a(2). Cost Measures

Section 1848(p) of the *Social Security Act*, as added by Section 3007 of the *Affordable Care Act*, requires the Secretary to "establish a payment modifier that provides for differential payment to a physician or a group of physicians" under the physician fee schedule "based upon the quality of care furnished compared to cost . . . during a performance period." The provision requires that "such payment modifier be separate from the geographic adjustment factors" established for the physician fee schedule. CMS believes that this provision requires the Secretary to establish a differential payment under the physician fee schedule to reflect "value," (e.g., the quality of care compared to cost) and that the value modifier is independent from the geographic adjustments applied under the fee schedule.

For purposes of this section of the law, CMS proposes to use total per capita cost measures and per capita cost measures for beneficiaries with these four chronic conditions: chronic obstructive pulmonary disease; heart failure; coronary artery disease; and diabetes. CMS would compare these cost measures to the quality of care furnished for use in determining the value modifier.

These cost measures are the same ones that CMS currently uses in its Physician Feedback Program. We appreciate CMS's consistent approach to measuring cost in this regard, and as long as the cost measures are price standardized and risk adjusted to ensure geographic and clinical comparability, we have no objections to the proposed cost measures.

Related to potential cost measures for future use in the value modifier, CMS notes that, by law, it is required to develop an episode grouper so that physicians may be compared on episode-based costs of care. CMS is currently in the process of selecting a prototype that can be tested and further developed during 2012.

As a transition to implementing the episode grouper, CMS notes that it could use cost measures based on the inpatient hospital Medicare Severity Diagnosis Related Groups (MS-DRG) classification system. Specifically, CMS could use allowed Parts A and B charges per beneficiary for all services furnished on the day of admission and through a specific number of days after the day of discharge. CMS seeks comments on whether it should pursue the MS-DRG approach in the near term while it develops episode-based cost measures for a significant number of high-cost and high-volume conditions in the Medicare program.

It is not apparent to us that there is any imperative to have cost measures based on the MS-DRG approach in the near term. To the extent that CMS is required to develop an episode grouper, we would encourage the agency to focus on that task and not dilute its limited resources on extraneous projects such as that suggested with the MS-DRG approach.

4(b). Assessing Physician Performance and Applying the Value Modifier

As CMS prepares to implement the value modifier in future rulemaking, there are a number of issues beyond quality and cost measures that it must consider and on which it solicits comments in this proposed rule. These issues include:

- How to create composites of measures of quality of care and of cost
- How to make appropriate risk and other adjustments to measures
- How to attribute beneficiaries to physicians to develop meaningful and actionable physician profiles, including issues of sample size.
- How to develop appropriate peer groups or benchmarks in order to compare physicians

Also, the statute allows the Secretary in 2015 and 2016 to apply the value modifier to specific physicians and physician groups the Secretary determines appropriate (i.e. Physicians who are outliers, physicians who treat the conditions that are most prevalent and/or most costly, among Medicare beneficiaries, etc.). CMS invites comment on this issue, too.

Regarding attribution methods, we would observe that they vary and are somewhat arbitrary. One method, which CMS has discussed using in the past, is the “plurality minimum” method, in which a beneficiary’s entire cost is attributed to the physician who performed the plurality of the E/M services, subject to a minimum percentage (i.e., 20 percent for individual physicians and 30 percent at the physician group level). Although this is an accepted method, it is not as accurate as some more sophisticated models. We are also concerned that such a method would penalize primary care by holding the primary care physician accountable for all the care a person receives, even though the primary care physician is providing only a portion of the patient’s care and may have little influence on patient choices or other physicians’ practice patterns.

Regarding benchmarking and peer groups, we note that a minimum number of patients as a sample size is a fairly common, but to some degree arbitrary, approach. In fact, the number of patients required for a certain level of precision might vary based on the actual measure under consideration. It would be better to require a measure of the precision, such as confidence interval.

4.d. Initial Performance Period

For 2015, the first year in which CMS will apply the value modifier, CMS proposes that the initial performance period be the full calendar year 2013. CMS proposes this performance period because some

claims for 2013 (which could be used in cost or quality measures) may not be fully processed until 2014. As such, CMS will need adequate lead time to collect performance data, assess performance, and construct and compute the value modifier during 2014 so that it can be applied to specific physicians starting January 1, 2015, as required by statute. As CMS has done in other payment systems, it plans to use claims that are paid within a specified time period, such as, 90-days after 2013, for assessment of performance and application of the value modifier for 2015. CMS will propose the specific cutoff period as part of the more detailed methodology for computation and application of the value modifier in future rulemakings.

We understand and recognize why CMS has chosen the initial performance period of calendar year 2013. However, we remain troubled that, as with other Medicare incentive programs (e.g., PQRS), CMS rewards or penalizes physicians today for what they did up to two years ago. If value is to be recognized and rewarded, CMS must find a way to do it in a more real-time manner. That will require CMS to move beyond its antiquated reliance on claims data for measuring physician performance. In an age in which data and information can be quickly transmitted and processed, we fail to understand why CMS remains stuck in a mode that requires it to take months, if not years, to determine which physicians bring value to the system.

4.e.(1). Systems-Based Care

Section 1848(p)(5) of the Social Security Act requires the Secretary, as appropriate, to apply the value-based modifier in a manner that promotes systems-based care. CMS seeks comment on how it might determine the scope of systems-based care and how best to promote it in applying the value modifier. For example, systems-based care might include an integrated group practice participation in the Shared Savings Program, a medical home, or an Innovation Center program that promotes systems-based care. CMS also could implement a method that attributes patients to a collection of physicians that treat patients in common to encourage better coordination of care. Finally, CMS notes that it could promote systems-based care by developing a common set of quality measures on which all providers would be evaluated.

We do not have specific comments for CMS in this regard, but we would encourage CMS to look at this provision as another opportunity to recognize and reward the patient-centered medical home (PCMH) as it brings value to the health care system. A patient-centered medical home integrates patients as active participants in their own health and well-being, and PCMH pilots around the country are demonstrating the value that this model of care brings to the health care system. Successful systems-based care will require, as foundational, that the primary care practices have transformed into highly functional models that can manage their patient populations within the system. Ensuring that payment encourages this and is sustainable will be critical for success.

Section IV.J. Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients

Certain services furnished to Medicare beneficiaries in the 3 days preceding an inpatient admission are considered "operating costs of inpatient hospital services" and are included in the hospital's payment under the hospital Inpatient Prospective Payment System (IPPS). This policy, known as the "3-day payment window, ." requires that a hospital include on the claim for a Medicare beneficiary's inpatient stay, the technical portion of any outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window.

In circumstances where the 3-day payment window applies to non-diagnostic services related to an inpatient admission furnished in a wholly owned or wholly operated physician practice, CMS proposes that Medicare would make payment under the physician fee schedule for the physicians' services that are subject to the 3-day payment window at the facility rate. That is, the services that are subject to the 3-day payment window

would be billed to Medicare similar to services that are furnished in a hospital, including an outpatient department of a hospital.

Thus, on or after January 1, 2012, CMS proposes that when a physician furnishes services to a beneficiary in a hospital's wholly owned or wholly operated physician practice and the beneficiary is admitted as an inpatient within 3 days (or, in the case of non-inpatient prospective payment system (non-IPPS) hospitals, 1 day), the payment window will apply to all diagnostic services furnished and to any non-diagnostic services that are clinically related to the reason for the patient's inpatient admission regardless of whether the reported inpatient and outpatient ICD-9-CM diagnosis codes are the same. As defined in federal regulations:

An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.'

Physician practices self-designate whether they are owned or operated by a hospital during the Medicare enrollment process.

To help implement this proposal, CMS would establish a new Medicare HCPCS modifier that will signal claims processing systems to provide payment at the facility rate. CMS proposes to pay only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3-day (or, in the case of non-IPPS hospitals, 1-day) payment window in a hospital's wholly owned or wholly operated physician practice. For codes without a TC/PC split, CMS proposes to pay the facility rate to avoid duplicate payment for the technical resources required to provide the services as those costs are supposed to be included on the hospital's inpatient claim for the related inpatient admission. The facility rate includes physician work, malpractice, and facility practice expense RVUs.

CMS would require that this modifier be appended to the physician preadmission diagnostic and admission related non-diagnostic services, reported with HCPCS codes, which are subject to the 3-day payment window policy. Each wholly owned or wholly operated physician's practice would need to manage its billing processes to ensure that it billed for its physician services appropriately when a related inpatient admission has occurred. The hospital would be responsible for notifying the practice of related inpatient admissions for a patient who received services in a wholly owned or wholly operated physician practice within the 3-day (or when appropriate 1-day) payment window prior to the inpatient stay. CMS would make the new modifier effective for claims with dates of service on or after January 1, 2012.

We have grave concerns about CMS's proposal. Practically speaking, it would seem to require family medicine practices that are wholly owned or wholly operated by a hospital to hold many, if not all, of their Medicare claims for at least three days before submitting them in order to determine or have the hospital inform them if a patient had a clinically related inpatient admission. Family physicians diagnose and treat a wide variety of conditions than can potentially result in subsequent, unexpected admission to a hospital. For instance, the patient seen for asthma on Tuesday may have an exacerbation on Thursday that necessitates admission.

If the practice submits a claim without the proposed modifier and the patient has an unforeseen admission that is clinically related within the 3 day window, the practice risks an overpayment or worse (e.g., charges of filing a false claim). The natural reaction will be to hold Medicare claims for at least 3 days to avoid that scenario, especially since CMS has not defined "clinically related" and has stated that "clinically related" does not depend on whether the reported inpatient and outpatient ICD-9-CM codes are the same.

Medicare already holds payment on clean claims for 14 days. This proposal will further delay payment on clean Medicare claims, to the detriment of practices that are attempting to serve Medicare patients. It will also further complicate the coding of Medicare claims by the addition of yet one more modifier to consider.

We understand that the law requires certain services furnished to Medicare beneficiaries within three days of an admission to be included in the hospital's payment under the IPPS. For planned admissions (e.g., elective surgery), this makes sense. However, for the many unplanned admissions that may be "clinically related" to an office visit in the prior three days, this proposal creates yet another headache. Therefore, we would advise CMS to withdraw and further refine its proposal in such a way that makes more sense for the practicing family physician. The AAFP is prepared to work with CMS in this regard.

Section IV.K. Hospital Discharge Care Coordination

In the proposed rule, CMS states that it is interested in broad public comment on how to further improve physician care coordination within the statutory structure for physician payment and quality reporting, particularly for a beneficiary's transition from the hospital to the community. To ensure that these hospital discharge care coordination services are appropriately valued, CMS is seeking comment on the specific physician activities and the associated resources involved in physician provision of effective care coordination surrounding a hospital discharge. CMS also invites comments on:

- Key physician activities associated with effective care coordination between the treating physician in the hospital and the beneficiary's primary physician in the community upon hospital discharge.
- The extent to which the clinical vignette for the hospital discharge and office visit codes appropriately incorporate hospital discharge care coordination activities.
- Whether the relative values assigned to these services under the physician fee schedule appropriately reflect the resources involved in performing activities that are essential to hospital discharge care coordination.
- Ways to ensure appropriate recognition of the resources involved in these services, specifically, the physician time and complexity of physician work as well as the associated practice expenses.
- The current coding structure for these services.
- Any other suggested changes to improve and emphasize care coordination, particularly for the beneficiary's transition from the hospital to the community.

We note that the hospital discharge day codes and other codes that CMS references in this context are among the E/M codes that CMS has requested the RUC to review elsewhere in the proposed rule. Our comments on that request and the appropriate valuation of E/M services are applicable here, too.

With respect to care coordination in general, the AAFP supports separate payment for the care management services provided by family physicians and their practices. Payment for care management services should be in the form of a designated care management fee paid on a per-member per-month basis as part of a "blended payment" model that also includes enhanced fee-for-service and performance-based incentives. Care management services include, but are not limited to, the management and coordination of complex medical cases to ensure quality and efficient use of health care resources. The [New Model of Family Medicine](#), as exemplified in the patient-centered medical home, anticipates that family physicians and their clinical staff will commonly provide such services. For those practices that are not yet qualified for a per-member-per month fee, a separate care management payment should value the resources required. The RUC has already performed much of the review of this component when it advised CMS on the PCMH demonstration. Family physicians already utilize their office nurses for coordination of services for their patients and assuring that appropriate testing and medication compliance occurs in a patient's treatment plan. Thus, the AAFP believes that health care delivery and payment systems, including Medicare, that use or contract for care management services should pay family physicians appropriately for these services.

With respect to transitions of care between the hospital and community in particular, the AAFP believes that safeguarding continuity of care through adequate communication is essential. The AAFP [policy](#) on "Hospitalists" provides guidelines for communication between inpatient and primary care physicians (when those are not the same) that may be equally relevant in non-hospitalist situations. Another related issue is the patient upon discharge who does not have a regular source of care and how best to serve this ever growing population.

Like CMS, we are interested in further improving physician care coordination within the statutory structure for physician payment and quality reporting, particularly for a beneficiary's transition from the hospital to the community. We welcome the opportunity to collaborate with CMS on this effort and stand ready to assist, as needed.

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

Sincerely,

A handwritten signature in black ink that reads "Lori Heim". The signature is fluid and cursive, with "Lori" on the top line and "Heim" on the bottom line.

Lori J. Heim, MD, FAAFP
Board Chair