AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

March 12, 2012

Ms. Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Tavenner:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents 100,300 family physicians and medical students nationwide. We are recommending that the Centers for Medicare and Medicaid Services (CMS) adopt a series of short term strategies for improving primary care payment as part of the proposed rule on the 2013 Medicare physician fee schedule that is currently under development by CMS.

The inadequate and dysfunctional payment system for primary care services remains one of the major barriers to the revitalization and transformation of primary care in the United States today. While many examples of payment reform are beginning to occur, most payment for primary care remains fee-for-service, with rates based on Medicare's physician fee schedule. Faced with increasing demands and inadequate financial resources, primary care practices are in an increasingly tenuous position, unable to redesign themselves into the model of the Patient Centered Medical Home using the teams and technology necessary to improve the quality and cost efficiency of care. As a result there are serious implications for access to care by patients throughout the country, and for the future physician workforce in the US. It is important to note that the strategies recommended below will not "save" primary care. However, if adopted by CMS, they will provide some desperately needed short-term help that family medicine and primary care needs until payment reform efforts are complete and long-term strategies can be identified and implemented.

In June 2011, the AAFP Board of Directors created a Task Force on Primary Care Valuation whose charge was to review and make recommendations to the AAFP Board of Directors for an alternative methodology(s) to value primary care services (evaluation and management services) provided by family physicians and other primary care physicians. The task force included representatives from other primary care organizations (i.e. American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association). It also included representatives from employer groups, private payers, and health policy organizations, such as the Urban Institute. Finally, we included observers from other organizations, including the Medicare Payment Advisory Commission and CMS. We have enclosed a complete list of the task force members for your information.

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Over the last seven months, the task force developed a series of recommendations that would improve payment for primary care services by primary care physicians in the near term and support principles for longer term payment reform developed by the Patient Centered Primary Care Collaborative. The AAFP Board of Directors approved those recommendations last week. Among them were the following recommendations, which we urge CMS to adopt as part of the proposed rule on the 2013 Medicare physician fee schedule:

RECOMMENDATION: That CMS create new codes for evaluation and management (E/M) services provided by primary care physicians with relative values that, at a minimum, would equal or exceed the median survey values from the 2005 survey of E/M codes (done by the primary care and other 'cognitive' specialties at that time). These new codes would be specifically for use only by primary care physicians who meet the definition as defined in the next recommendation.

Given that the bulk of primary care payment is derived from a fee-for-service payment model based on current E/M codes, the AAFP believes that it is important to ensure that the E/M codes used by primary care physicians accurately reflect the work required and be appropriately valued. The current E/M paradigm is based on "problem" identification and management. Primary care today is much more proactive, complex and strategic, including treatment of illness even before symptomatic presentation, extensive screening and prevention, and counseling -- comprehensive, coordinated, and continuous care. Codes for these E/M services provided in primary care today must accurately capture and value the physician work. Additionally, the practice expenses for these codes also need to be revalued to account for the significant infrastructure staffing and material expenses associated with care coordination and the continuity work of primary care. If CMS believes that new vignettes are necessary in further determining the physician work and practice expense values for such new codes, the AAFP would be very interested in working with CMS in this regard.

Additionally, new codes would avoid the difficulty of paying different specialties different amounts for the same codes, which is currently prohibited under the Medicare physician fee schedule. While the creation of new E/M codes for primary care services would ideally occur through the Current Procedural Terminology (CPT) process, the CPT schedule does not permit that in time for the 2013 Medicare physician fee schedule. Instead, we recognize that CMS has the ability to create new Healthcare Common Procedure Coding System codes at its discretion and can do so in time for the 2013 Medicare physician fee schedule.

Regarding the suggestion that CMS use the relative values recommended by the survey data in 2005, the AAFP believes that intensity of primary care work would be more appropriately acknowledged in the 2005 values. The AAFP accepts the notion that complexity and intensity of evaluation and management services provided by primary care physicians differ from similar services done by other specialties and believes the median survey values identified in 2005 best reflect, at a minimum, work values commensurate with new codes which can be created by CMS.

In sum, the AAFP believes that this recommendation has the advantage of appropriately highlighting the complexity of the work of primary care in a manner that may be readily utilized by both CMS and private payers. It should be noted that the recommendation is to use the new codes only for primary care physicians as defined below and that these new codes would replace the current E/M codes and values for such services provided by primary care physicians. Other ways of coding may be important to pursue in the long term, and we encourage CMS to consider this for further development.

In the meantime, these new codes are comprehensive for the acute, preventive, and chronic care provided in family medicine and primary care often in the same visit. Importantly, this is not just about patients with multiple co-morbidities. Further, CMS should make any necessary budget neutrality adjustments through an adjustment to the RVUs of all of the other codes in the Medicare physician fee schedule, rather than an adjustment to the conversion factor. An adjustment to the conversion factor will only serve to dilute the impact of these codes for primary care, whereas an adjustment to the RVUs of all other services will reinforce its impact.

RECOMMENDATION: The AAFP recommends that eligibility for enhanced payment options for primary care physicians be based on the following fundamental precepts. That the eligibility requirements reward demonstration of carrying out three definitional functions of primary care, namely 1) first contact, 2) continuity, and 3) comprehensiveness using claims to characterize every physician and replace the current claims-based process created by the Affordable Care Act (ACA) and revised by CMS.

1) **Additionally, a claims-based measure of coordination of care should be studied and considered for implementation (there currently is not one ready for use).**
2) **As Pediatric data is not available using Medicare data, further study on state Medicaid or other claims based data is needed.**

The definition of primary care in this country varies in different contexts but it consistently encompasses certain core values, including first contact of care, continuity of care, comprehensiveness, and coordination of care. The AAFP believes that to appropriately identify primary care physicians, CMS must use a working definition that reflects the core definitional elements. The following table provides a summary of the measurement of each element. We could not find a claims-based way to measure community/family functions of primary care.

Table 1: Core Definitional Elements of Primary Care

Primary Care Definitional Elements	How to measure and use for payment
first contact care	Family medicine, general internal medicine, general pediatrics and geriatrics (claims-based or NPI)
continuity of care	Patients who see this physician/clinic get the plurality of their care there (claims-based)
comprehensive care	Breadth and depth of ICD-9 codes used by physicians in Medicare claims
coordinated care	Patients who see more than 3 physicians are seen by a PCP or PC practice at least every 6 months
Bridges personal, family, and community	Undetermined

Physician specialty by itself does not necessarily define a primary care physician, as many internal medicine and family physicians work as hospitalists or in emergency rooms or have limited scope of care. The ACA defines primary care physicians by specialty combined with use of certain CPT codes that reflect common primary care services.

The measures above incorporate first contact, comprehensiveness, and continuity using Medicare claims data to identify primary care physicians as an alternative to the definition provided in the ACA. Since pediatric data is not available, the current model would serve as a proxy until other data is available. We have analyzed coordination of care, but this measure was so low using claims that it may not be sufficient to measure this function of primary care at this time. Utilizing key definitional elements of primary care will result in rewarding the appropriate physicians with additional payments for providing primary care.

Applying the filters as described in Appendix A of the enclosed task force report and using Medicare claims data allows identification of physicians who are providing care consistent with core elemental components of primary care with the exclusion of pediatrics. This approach is the first to attempt to define and identify primary care physicians in this way. Moving forward, we believe that it is essential to be able to appropriately identify those physicians providing primary care consistent with its most basic tenets. This approach is as complex as the nuances of the definition of primary care and as simple as recognizing core values we should expect from primary care. It is offered as an alternative to the definition set out in the ACA, and we have demonstrated that it captures a more functional definition of primary care.

We recognize that this definition may appear more complicated than the one that CMS currently uses in conjunction with the Primary Care Incentive Program (PCIP), and we would be happy to work with CMS to help you better understand how this new definition might be implemented. If this new definition is too complicated for CMS to implement immediately, we are open to the agency using the PCIP definition in the interim.

RECOMMENDATION: That CMS pay for the following services under the Medicare physician fee schedule using established relative value units (RVUs) when provided by primary care physicians as an interim strategy until this work is recognized under a care management fee:

- Telephone evaluation and management services (CPT codes 99441-99443)
- Collection and interpretation of physiologic data (CPT code 99091)
- Domiciliary, rest home, or home care plan oversight services (CPT codes 99339-99340)
- Anticoagulant management (CPT codes 99363-99364)
- Medical team conferences (CPT codes 99366-99367)
- Care plan oversight services (CPT codes 99374-99380)

All of the services covered by this recommendation have established RVUs. However, CMS does not pay for them separately under the Medicare physician fee schedule. CMS considers most of them "bundled" with other services paid under the fee schedule. While some of these services and corresponding codes ultimately would be part of a care management fee (as planned for example in the Comprehensive Primary Care Initiative), the AAFP believes that paying for them now on a fee-for-service basis is a sound and interim short-term strategy. All are integral to primary care, and we note that the Relative Value Scale Update Committee (RUC) has made a similar recommendation to CMS.

To be sure, primary care is moving toward a blended system of payment, and these codes ultimately may be covered in a care management fee rather than on a fee-for-service basis. In the meantime, the services described above are not part of face-to-face care and validly fall outside the current bundled payments for E/M services.

RECOMMENDATION: That CMS value and pay for the online evaluation and management service (i.e., CPT code 99444) provided by primary care physicians.

CPT code 99444 (Online evaluation and management service provided by a physician to an established patient . . .) does not have established RVUs and is not covered under the Medicare physician fee schedule. The RUC attempted to value this code in 2007 and was not successful. The RUC discussed code 99444 and concluded that the definition of work and physician time and complexity involved in this service were unclear, therefore making it difficult to recommend a specific work relative value.

The AAFP believes that the service represented by this code is as integral to primary care as the other non-face-to-face services described in the recommendation above. Since CMS has the ability to value services independent of the RUC, the AAFP recommends that CMS proceed to work directly with AAFP and other organizations that represent primary care physicians to establish a value for this service and implement payment for it under the Medicare physician fee schedule in 2013.

We appreciate your consideration of these recommendations and welcome the opportunity to discuss them with you and your staff. To pursue such conversations, please contact Mr. Robert Bennett, Federal Regulatory Manager at the AAFP at rbennett@aafp.org or at 1-800-274-2237, extension 2522.

Sincerely,

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

Enclosures

RAG:kjm

Appendix A. Identifying Primary Care Providers: Memo for the Physician Payment Taskforce of the AAFP

Prepared by the Robert Graham Center

Studies have shown a significant income gap between primary care physicians and non-primary care physicians. This discrepancy negatively affects medical student choice of primary care as a profession and threatens the primary care workforce. Altarum demonstrated that primary care physicians income would need to increase to 70-80% of specialty income to positively change student interest in primary care. For family physicians, this readjustment of income discrepancy could be achieved with a 32% increase in the median income.

The definition of primary care in this country varies in different contexts but it consistently encompasses certain core values including first contact of care, continuity of care, comprehensiveness, and coordination of care (Table 1). In order to appropriately identify primary care physicians, we must use a working definition that reflects the core definitional elements. Physician specialty does not necessarily define a primary care physician as many internal medicine and family physicians work as hospitalists or in emergency rooms. The Affordable Care Act (ACA) defines primary care physicians by specialty combined with use of certain CPT codes which reflect common primary care services.

We propose the following measures that incorporate first contact, comprehensiveness, and continuity using Medicare claims data to identify primary care physicians as an alternative to the definition provided in the ACA. We include a measure of coordination of care in our analysis but this measure was so low using claims that it may not be sufficient to measure this function of primary care at this time.We feel that utilizing key definitional elements of primary care will result in rewarding the appropriate physicians with additional payments for providing primary care. Table 1 provides a summary of the measurement of each element. We could not find a claims-based way to measure community/family functions of primary care.

Table 1: Core Definitional Elements of Primary Care

Primary Care Definitional Elements	How to measure and use for payment
first contact care	Family medicine, general internal medicine, general pediatrics (claims-based or NPI)
continuity of care	Patients who see this physician/clinic get the plurality of their care there (claims-based)
comprehensive care	Breadth and depth of ICD-9 codes used by physicians in Medicare claims
coordinated care	Patients who see more than 3 physicians are seen by a PCP or PC practice at least every 6 months
Bridges personal, family, and community	Undetermined

Comprehensiveness:
Comprehensiveness is a central element of most definitions of primary care. As the point of first contact, primary care providers must diagnose and often treat a wide range of medical conditions. While there is little disagreement on this point, there is not a widely used measure of comprehensive care.

The following lays out a simple approach to characterizing the extent to which an individual physician provides comprehensive care. The basic idea is that over a certain periods of time, physicians will treat patients with a number of conditions identified by ICD-9 codes. Physicians providing more comprehensive care will generally treat a larger number of conditions. A simple count of the number of different conditions treated is a misleading measure as even sub-specialists such as cardiologists or neurologists who focus their practice on a narrow set of conditions will still treat patients with a wide range of additional, co-morbid conditions. A simple count measure is also sensitive to the total number of patients treated over a period of time.

Below is a measure that takes into account the overall distribution of conditions treated and is relatively insensitive to the number of patients treated. The approach has three steps: 1) for each physician, create a frequency distribution of all of the conditions treated in the course of a year, 2) rank order these conditions from the most frequent to the least frequent and calculate cumulative frequencies, 3) set threshold of the cumulative frequencies 80% to cut off the long tail of codes that appear infrequently, and then count the ICD-9 codes that account for distribution below the threshold value. The rank-ordered distribution for each physician is unique. Distributions that are flatter indicate more comprehensive care, while those skewed to left indicate less comprehensive care. The appropriate threshold is a matter of judgment, and approaching a 100% threshold will include more of the low-frequency conditions.

Table 2: Cumulative frequencies of ICD-9 codes as a measure of comprehensiveness

Specialty	Number of claims	Average number of ICD9 codes	Threshold percentage for minimum 12 ICD-9 codes
Family Medicine	1891	46	91
Internal Medicine	2759	39	85
Geriatrics	2887	52	95
General Practitioner	1897	38	80

Table 2 demonstrates 91% of family physicians billed for 12 or more ICD-9 codes for 80% of their practice and hence would be included as primary care through this definition. A slightly higher number of general internists and general practitioners would be excluded using this threshold. Geriatricians show more robust comprehensiveness using this measure due to the fact that the population they are treating is older with comorbid conditions. This difference does not negatively affect family physicians.

Continuity:
Continuity of care can be reflected in consistency of provider for multiple physician visits.

The approach to capture provider continuity of care involves 1) examining primary care physician visits in cases where the patient had 2 or more visits in that year 2) determine if visit was with same provider.

Table 3 demonstrates that 57% of primary care visits by the same captures 90% of family physicians, and nearly 90% of all four specialties (Table 5).

Coordination of care:
Primary care should involve coordination of other health services and visits with other physicians. A measure of regular visits at least every 6 months with primary care physician for patients who saw at least 3 physicians would reflect a physician's coordination of patients' care. This could reflect patients being referred to specialists or other care settings and then coming back to primary care. It does require that a patient see at least 2 other physicians which does not apply to most patients given that this pattern of care is only 16.7% of family medicine patients. For this reason it may not be an accurate measure of coordination—or may not be applicable for a sufficiently large enough pool of primary care patients to warrant use. Task Force Members should decide.

Table 3. Values for the three functions of primary care that capture 90% of family physicians

	Captures 90% of Family Physicians				
Specialty	Comprehensiveness	Continuity	Coordination	Physicians in Sample	Weighted
General practice	5	51.2%	9.3%	600	6,339
Family practice	12	57.1%	16.7%	4,975	46,161
Internal medicine	7	55.2%	18.0%	4,749	52,467
Geriatric medicine	17	68.9%	25.0%	66	695
Note: Data are weighted. The 10th Decile for Family Practice was used to create overall primary care inclusion measure					

Excluding hospitalists:
As mentioned early, traditional primary care specialties are practicing as hospitalists and emergency physicians. A primary care incentive payment or bonus would not be best allocated to these physicians who are already being reimbursed at higher rates. It is useful, then, to have a measure that excludes those physicians for whom a disproportionate amount of their billing is from hospital or emergency room visits.

Table 4: Primary care physicians for whom the majority of claims are from hospital-based care

Specialty	% physicians who bill >80% charges as hospital codes	% of allowed charges are hospital codes?
Family Medicine	10.7	20.9
Internal Medicine	23.0	38.3
Geriatrics	16.6	33.5
General Practitioner	7.67	13.1

Table 4 demonstrates that you would exclude 10% of family physicians using a threshold of 80% as the maximum amount of hospital billing codes. This threshold would reasonably rule out those practicing predominantly in hospital settings without excluding too many physicians. Other specialties are affected differently, which is logical as more internal medicine physicians practice as hospitalists relative to family physicians.

Applying all primary care definitional elements:
When these three definitional or functional filters, created using Medicare data, are applied to primary care physicians, more than 75% of family physicians would be captured (Table 5). Only geriatricians are captured at a higher rate (90%). Slightly more family physicians would be captured without the coordination criteria. Rural physicians do slightly better than urban physicians (76.7% of urban FPs vs. 79.2% of rural FPs) owing to higher levels of comprehensiveness and continuity.

Conclusion:
Applying the above filters using Medicare claims data allows us identify physicians who are providing care consistent with core elemental components of primary care. This approach is the first to attempt to define and identify primary care physicians in this way. Moving forward, with legislation geared to promote primary care and efforts underway to improve primary care physician incomes, it is essential to be able to appropriately identify those physicians providing primary care consistent with its most basic tenents. This approach is as complex as the nuances of the definition of primary care, but as simple as recognizing core values we should expect from primary care. It is offered as an alternative to the definition set out in the ACA, and we have demonstrated that it captures a more functional definition of primary care.

Table 5: Application of all three primary are function filters to physician eligibility

	Percent of Physicians Meeting Threshold					
	Comprehensiveness	Continuity	Coordination	All Criteria	Physicians in Sample	Weighted
1. All Primary Care (PC) Physicians						
General practice	79.6%	87.7%	80.1%	59.2%	600	6,339
Family practice	90.7%	90.1%	89.3%	76.7%	4,975	46,161
Internal medicine	85.1%	89.1%	90.9%	71.7%	4,749	52,467
Geriatric medicine	94.6%	99.4%	95.6%	89.9%	66	695
2. Non-Hospitalist PC						
General practice	79.4%	88.1%	80.2%	59.4%	551	5,853
Family practice	92.2%	91.7%	90.5%	79.7%	4,348	41,232
Internal medicine	85.7%	93.5%	92.7%	77.4%	3,541	40,389
Geriatric medicine	93.6%	99.7%	94.7%	88.3%	55	580
2.a Urban						
General practice	79.9%	89.5%	76.6%	57.2%	293	3,730
Family practice	91.3%	92.6%	89.7%	79.2%	2,926	31,579
Internal medicine	84.6%	94.0%	92.5%	77.0%	2,840	34,853
Geriatric medicine	96.5%	99.6%	94.3%	90.7%	49	532
2.b Rural						
General practice	89.2%	83.4%	88.7%	72.5%	155	1,093
Family practice	95.4%	88.3%	93.1%	81.3%	1,393	9,363
Internal medicine	94.1%	89.8%	94.2%	80.9%	635	4,876
Geriatric medicine	61.5%	100.0%	100.0%	61.5%	6	48