



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 29, 2013

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 110,600 family physicians and medical students nationwide, I write in response to the [proposed](#) "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014" as published by the Centers for Medicare & Medicaid Services (CMS) in the July 19, 2013, *Federal Register*.

The AAFP thanks the agency for continuing to propose short term payment strategies that recognize "primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth." We applaud CMS for promoting the value of primary care. This commitment to primary care should begin to address the looming shortage of primary care physicians and will improve the delivery of healthcare in America.

However, the proposed fee schedule includes an estimate that the sustainable growth rate (SGR), which is the statutory formula used to determine Medicare physician payments, will decrease 24.4 percent in 2014 unless Congress intervenes. An AAFP analysis of the proposed cut shows the typical family physician would lose a total of \$89,763 and a three-physician practice would lose \$269,289 in revenue next year. No small business can sustain itself in the face of such drastic revenue reductions.

The AAFP encourages CMS and Congress to work together and avert this devastating cut. The AAFP calls on Congress to repeal the SGR and replace it with a formula that

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includes higher payment for primary care. We also recommend continuing efforts to develop a new and effective physician-endorsed payment model. The AAFP believes that to achieve meaningful health system reform, we must also have meaningful Medicare physician payment reform.

Further AAFP's comments on the proposed Complex Chronic Care Management Service (CCCM) codes are included later in this letter, but the AAFP reiterates our recommendations regarding the appropriate method for Medicare to pay for primary care services as outlined in our March 27, 2013, [letter](#) to the agency. We continue to believe that the complexity of the ambulatory evaluation and management (E/M) services that primary care physicians must "fit" into the time available for the typical patient visit is sufficiently distinct to merit dedicated codes and higher relative values than are currently assigned to existing office or other outpatient E/M codes. The AAFP supports a concept called "complexity/density" to describe and quantify this reality. We recommend that CMS create, as part of the 2014 MPFS, separate primary care E/M Healthcare Common Procedure Coding Systems (HCPCS) codes for office or other outpatient services to new and established patients with correspondingly higher relative values. While we are disappointed that CMS did not propose these codes within the 2014 rule making cycle, we also recognize the concept is relatively new and perhaps challenging for CMS to implement through existing regulations and within a fee-for-service payment system. Nevertheless, the AAFP encourages CMS to reconsider the recommendations in our March 27 letter, and we stand willing to work with the agency and other stakeholders to develop payment for separate primary care E/M codes.

Though falling outside the purview of this particular proposed regulation, we nevertheless use this comment period to react to the Medicare Primary Care Incentive Program (PCIP). Section 5501(a) of the *Affordable Care Act* authorizes PCIP payments beginning in 2011 and ending in 2015. The program is intended to augment Medicare payment for physicians with a Medicare specialty designation of family medicine, geriatric medicine, pediatric medicine, or internal medicine as well as nurse practitioners, clinical nurse specialists, and physician assistants. Physicians and other qualified health care professionals are eligible if primary care services with certain codes (CPT codes 99201 through 99215 and 99304 through 99350) accounted for at least 60 percent of their allowed charges under the MPFS in the qualifying calendar year. The incentive payments are equal to 10 percent of the Medicare paid amount for the codes, which include office and outpatient visits, home services, nursing facility services, and custodial care.

Compared with [data from the 2011 PCIP](#), the [data from the 2012 PCIP](#) shows the incentive program paid nearly 18.5 percent more. While an improvement, only 68,961 family physicians qualified in 2012 resulting in an average annual payment of only \$3,650 per family physician. Though the AAFP continues to support the agency's implementation of the PCIP, we remain concerned that the payment amounts associated with the 2011 and 2012 PCIP remain inadequate to address the current payment discrepancies between primary care physicians and medical specialists that discourage medical students from pursuing careers in primary care. We are equally concerned that some family physicians, especially those practicing medicine in rural areas, are disqualifying

themselves from receiving the PCIP by billing codes and services that are not associated with the PCIP but are reasonable and necessary for the proper care of their patients. The AAFP, therefore, calls on CMS and Congress to refocus on the original intent of the PCIP and to restrict PCIP qualification to primary care physicians as identified through use of the core definitional elements specified by the AAFP in our March 27, 2013, letter to the agency.

To improve the final 2014 Medicare physician fee schedule rule, in summary the AAFP:

- Generally supports the CMS proposal to pay for CCCM services in 2015 and agrees that resources required to properly provide CCCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes;
- Reiterates our concern that the current office/outpatient E/M codes are not adequate for primary care and that CMS needs to create dedicated codes for primary care physicians;
- Urges CMS to ramp up and expand the Comprehensive Primary Care Initiative (CPCI) and pay a risk-adjusted care management fee for all Medicare beneficiaries as part of a blended-payment model for the patient-centered medical home (PCMH);
- Appreciates efforts to align the Physician Quality Reporting System (PQRS) with other quality improvement programs but questions the proposal to increase the number of reported PQRS measures from three to nine;
- Supports CMS' efforts to adjust relative value unit (RVU) amounts for procedures in order to pay more accurately for services; however, we also encourage CMS to not pay significantly more for services in the outpatient or ambulatory surgical center setting than in the physician office setting;
- Appreciates the increasingly significant steps to identify and address potentially misvalued codes, although we believe more should be done to ensure that Medicare is not reimbursing based on biased data that further exacerbates the undervaluation of primary care services;
- Advocates for the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal;
- For purposes of Medicare Telehealth Services, concurs with a proposed change to define "rural" to include geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) in order to allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites;
- Supports a technical correction that clarifies that those auxiliary personnel performing "incident to" services must furnish services in accordance with applicable state law;
- Supports removing the initial preventive physical examination (IPPE) as a prerequisite for abdominal aortic aneurysm (AAA) screenings to conform with the recommendation by the United States Preventive Services Task Force;
- Supports expanded coverage and access to colorectal cancer screening by allowing non-physician practitioners to order the screening fecal occult blood tests so long as they function under the direction and responsible supervision of a practicing and licensed physician;

- Commends the agency for the improvements made to the Physician Compare website and also urges CMS to extend the physician preview period and to translate physician quality scores into consumer friendly terms;
- Finds CMS proposals to implement the value-based payment modifier as reasonable and appreciates CMS not initially subjecting penalties to groups of 10-99 eligible professionals; and
- Continues to support efforts to align quality reporting programs and innovation initiatives yet also expresses increasing concerns with Meaningful Use Stage 2 expectations.

Section II.A.3 Changes to Direct PE Inputs for Specific Services

The AAFP appreciates CMS' efforts to adjust RVU amounts for procedures in order to pay more accurately. CMS typically establishes two practice expense (PE) RVUs for procedures that can be furnished in either a nonfacility setting, like a physician's office, or a facility setting, like a hospital. The proposed regulation discusses that, "for some services, the total Medicare payment when the service is furnished in the physician office setting exceeds the total Medicare payment when the service is furnished in a hospital outpatient department or an ambulatory surgical center. When this occurs, we believe it is not the result of appropriate payment differentials between the services furnished in different settings. Rather, we believe it is due to anomalies in the data we use under the MPFS and in the application of our resource-based PE methodology to the particular services."

The AAFP agrees. PE RVU data heavily relies on the voluntary submission of information by individuals furnishing the service, and the agency has "little means to validate whether the information is accurate or reflects typical resource costs." We also concur with CMS that "such incomplete, small sample, potentially biased or inaccurate resource input costs may distort the resources used to develop nonfacility PE RVUs used in calculating MPFS payment rates for individual services."

Given the differences in the validity of the data used to calculate payments, CMS argues that the nonfacility MPFS payment rates for procedures that exceed those for the same procedure when done in a facility result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared to the more accurate outpatient prospective payment system (OPPS) data. To improve the accuracy of MPFS nonfacility payment rates beginning in 2014 and for each calendar year thereafter, CMS proposes to use the current year OPPS or ambulatory surgical center (ASC) rates as a point of comparison in establishing PE RVUs for services under the MPFS. CMS proposes to limit the nonfacility PE RVUs for individual codes so that the total nonfacility MPFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting. If this proposal is finalized, CMS will reduce the nonfacility PE RVU rate, so the total nonfacility payment does not exceed the total Medicare payment made for the service in the facility setting. The AAFP concurs with this approach as a step toward more accurately paying relative practice expense costs.

CMS included Table 72 in the proposed rule; it illustrates the estimated impact of selected policy proposals on total allowed charges, by specialty. Compared with other specialties and due to budget neutrality requirements, CMS estimates family physicians will receive a 1 percent increase due to the proposed changes in direct PE inputs. Since this policy change helps address the current payment gap between primary care physicians and medical specialists and also because CMS proposes to use more accurate data, the AAFP supports this proposal.

We appreciate that CMS referenced the Medicare Payment Advisory Commission's (MedPAC) March 2012 report to Congress in which MedPAC recommended that Medicare seek to pay similar amounts for similar services across payment settings, taking into account differences in the definitions of services and patient severity. Thus, the AAFP encourages CMS also to consider site-of-service payment parity policies from the opposite perspective. Namely, CMS should not pay significantly more for services in the outpatient or ASC setting than in the physician office setting. From a global cost perspective, and as further discussed in the AAFP's August 20, 2012, [letter](#) to CMS sent in response to the solicitation of comments regarding outpatient status, the AAFP encourages CMS to create incentives for services to be performed in the least costly location, such as a physician's office, rather than in more costly locations, such as the inpatient, outpatient, or ASC settings.

Section II.A.4 Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments

CMS requests comments on the best means for collecting information on the frequency, type, and payment for services furnished in off-campus provider-based departments of hospitals. In the proposed rule, CMS mentions three options to collect this information and requests public feedback. The agency could:

1. Create a new place of service code for off-campus departments of a provider;
2. Create an HCPCS modifier that could be reported with every code for services furnished in an off-campus provider-based department of a hospital; or
3. Ask hospitals to break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report, which some hospitals already do voluntarily.

Given the increasing instances in which hospitals acquire physician practices, the AAFP fully agrees that CMS should collect and analyze additional information to understand these arrangements. Of the three options, the AAFP supports the third since it places the reporting requirement on hospitals, which are ostensibly benefitting from the purchase of the physician's practice. We find the first and second options as unacceptable since new place-of-service codes or modifiers create a reporting burden for practicing family physicians. If CMS decides to go with one of those two options, a new place-of-service code would be preferable to a HCPCS modifier.

II.B. Misvalued Codes

In recent years, CMS and the Relative Value Scale Update Committee (RUC) have taken increasingly significant steps to identify and address potentially misvalued codes. CMS

and the RUC now identify and review potentially misvalued codes annually instead of every five years. The AAFP appreciates these recent improvements, although we believe more should be done to ensure that Medicare is properly paying for primary care physician services rather than paying based on biased data that further exacerbates the undervaluation of primary care services.

The agency recently entered into contracts with RAND Corporation and the Urban Institute to develop validation models for RVUs. The AAFP looks forward to reviewing and commenting on these models once available. In late 2012, CMS established a process for the public to nominate potentially misvalued codes, and in this proposed rule, CMS states they “did not receive publicly nominated potentially misvalued codes for inclusion in this proposed rule. We look forward to receiving new code nominations for inclusion in the 2015 proposed rule to continue with our efforts to identify potentially misvalued codes.”

CMS then discusses input the agency received from Medicare contractor medical directors (CMDs) to develop a list of potentially misvalued codes. The CMDs identified fourteen codes as potentially misvalued.

The regulation then discusses methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Without actually making any substantive proposals, CMS discusses efforts to improve the valuation of the global surgical package by measuring post-operative work. The AAFP reiterates comments we made in a February 20, 2013, [letter](#) to CMS that specifically discusses efforts to improve the valuation of the global surgical package. We maintain that the global surgical packages are inflated in terms of the number and level of post-operative visits assumed to be included and incorporated in the value of the codes in question. Also at issue is who is providing these services; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeons focus only on the surgery itself. We strongly urge CMS to revisit recommendations the AAFP made in that letter and to continue efforts to improve the valuation of the global surgical package.

II.D. Medicare Economic Index

The Medicare Economic Index (MEI) is a measure of practice cost inflation developed as a way to estimate annual changes in physicians’ operating costs and earnings levels. In the proposed 2014 MPFS, CMS suggests revising the MEI based on the recommendations of its MEI Technical Advisory Panel. CMS does not propose to rebase the MEI and will continue to use the data from 2006 to estimate the cost weights, arguing that these are the most recently available, relevant, and complete data the agency has available to develop these weights.

CMS also proposes to reorganize the cost categories and to select the price proxies in the MEI. CMS proposes several revisions to the 2006-based MEI; one significant change is to reclassify expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation. The AAFP concurs with this proposal for reasons CMS outlines and since this policy is more consistent with how

services by non-physician practitioners are treated in the resource-based relative value scale (RBRVS).

The AAFP is concerned with the CMS proposal to use the Employment Cost Index (ECI) for Wages and Salaries for Hospital Workers (Private Industry) as a price proxy for non-physician, health-related staff compensation. Though CMS argues that the ECI for hospital workers has an occupational mix that approximates that in physicians' offices, the AAFP does not agree. Unfortunately, we do not have an alternative to suggest at this time. On the other hand, the AAFP agrees with the proposed change in the price proxy for Fixed Capital, since it represents the types of fixed capital expenses most likely faced by physicians.

II.E. Geographic Practice Cost Indices

CMS is required to develop separate geographic practice cost indices (GPCI) 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 three years. The *American Taxpayer Relief Act* extended the 1.0 work GPCI floor through December 31, 2013. Except for Alaska, the current 1.0 physician work floor expires then, unless Congress intervenes.

It is longstanding AAFP [policy](#) to advocate for the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas).

Though we recognize that CMS is attempting to update data used that determines GPCI amounts, that effort does not mitigate the fact that GPCIs reinforce the high cost of Medicare in some areas and discourage practicing in rural and underserved areas since those areas tend to receive lower GPCI adjustments.

II.F. Medicare Telehealth Services for the Physician Fee Schedule

In this regulation, CMS proposes to modify their telehealth policies so that originating Medicare telehealth sites defined as rural health professional shortage areas (rural HPSA) as those located in rural census tracts as determined by the Office of Rural Health Policy. The AAFP fully supports this approach. We concur that this change should define "rural" to include geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) because it would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. Likewise, we agree with CMS that adopting the more precise definition of "rural" for this purpose would expand access to health care services for Medicare beneficiaries located in rural areas.

The AAFP policies on [Telemedicine](#) and [Telemedicine, Licensure and Payment](#) do not limit coverage and payment to certain geographic areas, so the AAFP considers the proposal to include more areas as favorable.

In the 2013 MPFS, CMS finalized payment policy for two new CPT transitional care management (TCM) codes. TCM codes are comprised of one face-to-face visit within the specified time frames following a discharge, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and licensed clinical staff under his or her direction. In the 2014 proposed MPFS, CMS states that interactions between the furnishing practitioner and the beneficiary described by the required face-to-face visit component of the TCM services are sufficiently similar to services currently on the list of Medicare telehealth services for these TCM services to be added. Specifically, CMS believes that the required face-to-face visit component of TCM services is similar to the office/outpatient E/M visits described by CPT codes 99201-99205 and 99211-99215. Therefore, CMS proposes to add CPT codes 99495 and 99496 to the list of telehealth services for 2014, and the AAFP fully supports this approach.

II.H. Requirements for Billing “Incident to” Services

“Incident to” services and supplies are those “which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in physicians’ bills.” These are services and supplies furnished as “incident to” the professional services of a physician. Medicare regulations set forth specific requirements that must be met in order for physicians and other practitioners to bill Medicare for “incident to” services. In addition, regulations specific to each type of practitioner (clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives) stipulate who is allowed to bill for “incident to” services.

In this proposed rule, the agency discusses recently becoming aware of several situations where Medicare was billed for “incident to” services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. The physician or practitioner billing for the services would have been permitted under state law to personally furnish the services, but the services were actually provided by auxiliary personnel who were not in compliance with state law in providing the particular service. Practitioners authorized to bill Medicare for services that they furnish to Medicare beneficiaries are required under Medicare to comply with state law.

However, the Medicare requirements for services and supplies incident to a physician’s professional services do not specifically make compliance with state law a condition of payment for services and supplies furnished and billed as “incident to” services. Nor do any of the regulations regarding services furnished “incident to” the services of other practitioners/physicians contain this requirement. Thus, Medicare has had limited recourse when services furnished incident to a physician’s or practitioner’s services are not furnished in compliance with state law.

To rectify this inconsistency, CMS proposes amendments to applicable regulations to ensure that auxiliary personnel providing services to Medicare beneficiaries incident to the services of other physicians and practitioners do so in accordance with the requirements of the state in which the services are furnished and to ensure that Medicare dollars can be recovered when such services are not furnished in compliance with the

state law. Specifically, CMS proposes and the AAFP fully supports additional language to applicable regulations stating, "Services and supplies must be furnished in accordance with applicable State law." CMS is also proposing to amend the definition of auxiliary personnel to require that the individual performing "incident to" services "meets any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished."

The AAFP agrees with this approach and appreciates that CMS relies primarily on the states to regulate the health and safety of their residents in the delivery of health care services. We consider this change as a technical correction that clarifies existing payment policies.

II.I. Complex Chronic Care Management Services

For 2015, CMS proposes to establish a separate payment under the MPFS for Complex Chronic Care Management (CCCM) services furnished to patients with multiple (two or more) complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

In general, the AAFP supports the CMS proposal to pay for CCCM services despite the agency's delayed 2015 implementation date. CMS proposals on the CCCM services are generally consistent with previous AAFP advocacy, and we consider payment for CCCM services as another appropriate, albeit short-term, step in the direction of paying primary care physicians a monthly care management fee for all beneficiaries who are receiving services from a patient-centered medical home (PCMH).

The AAFP agrees with the agency that resources required to properly provide CCCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. We continue to believe that the care management included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face management work involved for certain categories of beneficiaries. Once again, the AAFP reiterates our [position](#) that the current office/outpatient E/M codes are not adequate for primary care and that CMS needs to create dedicated codes for primary care services provided by primary care physicians.

The AAFP agrees that successful efforts to improve chronic care management for patients with multiple chronic conditions could improve the quality of their care while simultaneously decreasing costs.

The AAFP looks forward to continuing to partner with CMS to develop standards for furnishing CCCM services to ensure that the physicians who bill for these services have the capability to provide them. We agree with the agency that not all physicians and qualified non-physician practitioners who wish to furnish CCCM services currently have the practice capability to fully provide the scope of services without making additional investments in technology, staff training, and the development and maintenance of systems and processes to furnish the services.

We strongly advise CMS against needlessly prescribing that practices providing CCCM services be required to employ an advanced practice registered nurse (APRN) or physician assistant (PA). If CMS required employment of APRNs and PAs for CCCM services, the AAFP believes the requirement would deter small and rural practices from offering CCCM services.

To ensure adequate funding for the CCCM services, the AAFP encourages CMS to continue the practice of applying a budget-neutral adjustment to the conversion factor, so the impact is spread across the entire Medicare physician fee schedule. Ideally, some of the savings generated elsewhere in Medicare (e.g., in reduced hospitalizations under Part A) would also flow to the physicians providing CCCM services. The AAFP believes that applying the CCCM services in a budget-neutral manner will promote sustainable practice environments and allow physician investment in new ways of improving patient care. The AAFP looks forward to providing further comments on the proposed practice standards that CMS will develop to provide high quality and safe CCCM services.

CMS states that, "Should this proposal become final policy, it may be a short-term payment strategy that would be modified and/or revised to be consistent with broader primary care, and care management and coordination services if the agency decides to pursue payment for a broader set of management and coordination services in future rulemaking." The AAFP appreciates the agency's statements and this short-term strategy. In the long-term, the AAFP urges CMS to expand the Comprehensive Primary Care Initiative (CPCI) approach and pay a risk-adjusted care management fee for all Medicare beneficiaries as part of a blended-payment model for the PCMH. The AAFP believes all Medicare patients can benefit from care management, not just those with complex and multiple chronic conditions.

Given the complexities inherent in the CMS proposal to pay CCCM service codes, the AAFP sees it as indicative that care management is not well suited for a fee-for-service payment structure. Thus, the AAFP urges CMS to reconsider a capitated monthly payment for primary care management services. We believe it would be simpler and more efficient that CMS pays for care management on a per-member per-month basis, as is done under CPCI.

Patient Eligibility for Separately Payable Non-Face-to-Face CCCM Services

The AAFP agrees that CMS should initially offer these services to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Furthermore, the AAFP agrees with the proposed scope of CCCM services, since the requirements are consistent with what is expected in a PCMH.

Standards for Furnishing CCCM Services

CMS seeks comments on practice standards for furnishing CCCM services. According to [Guidelines for Patient-Centered Medical Home \(PCMH\) Recognition and](#)

[Accreditation Program](#) released by the AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, we support CMS relying on existing PCMH standards such as the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, The Joint Commission, or URAC, which are entities that are already formally recognizing primary care practices as PCMHs, which will have the requisite capabilities to furnish CCCM services. To ensure only qualified primary care physicians and qualified non-physician practitioners offer CCCM services, the AAFP strongly urges CMS to permit providers practicing within designated PCMHs to use these codes without subjecting the provider or the practice to any further documentation that they are qualified to provide the service.

Billing for Separately Payable CCCM Services and Obtaining Informed Consent from the Beneficiary

The AAFP does not agree with the CMS proposal to create separate G-codes for CCCM services. Since CMS did not propose using the existing CPT codes that relate to CCCM services, the AAFP encourages CMS to work further with the CPT Editorial Panel and the national specialty societies to revise these CPT codes so that primary care physicians use CPT codes for CCCM services beginning in 2015.

The AAFP also does not agree with the CMS proposal to value these new codes as 90-day services. The AAFP advocates for primary care physicians to receive a monthly care management fee for all beneficiaries who are receiving services from a PCMH. Therefore, the AAFP calls on CMS to value the new CCCM codes as 30-day services, which would further align the CMS proposal with how CPT structured their related CCCM codes.

CMS states that “we propose that billing for subsequent complex chronic care management services (GXXX2) would be limited to those 90-day periods in which the medical needs of the patient require substantial revision of the care plan...” The AAFP interprets that as implying that CMS does not expect CCCM services to be ongoing and continuous. However, since CMS proposes that eligible patients are those “with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,” the AAFP is unsure how a patient of that description would not need CCCM services on an ongoing basis. We do not see a significant enough distinction between CCCM services offered initially from CCCM services offered subsequently to merit separate codes. Therefore, the AAFP urges CMS to reconsider the need for a separate CCCM code to describe a “subsequent” service. The AAFP believes a single code for CCCM services is administratively simpler for both physicians and CMS.

CMS proposes that “before the practitioner can furnish or bill for these services, the eligible beneficiary must be informed about the availability of the services from the practitioner and provide his or her consent to have the services provided...” and later that, “A practitioner would need to reaffirm with the beneficiary at least every 12 months whether he or she wishes to continue to receive complex chronic care management services during the following 12-month period.” The AAFP supports requiring advanced

beneficiary consent, since we believe patients receiving care should be encouraged to prospectively select their primary care physician.

The AAFP concurs with the CMS proposal to limit CCCM services to patients who do not reside in a facility setting. We also agree with the proposal to pay only one claim per beneficiary per time period. As previously noted, we urge CMS to consider CCCM services within a 30-day period rather than the proposed 90-day period.

CCCM Services and the Annual Wellness Visit (AWV) (HCPCS codes G0438, G0439)

The AAFP urges CMS to reconsider the proposal that would require patients to receive an annual wellness visit (AWV) or initial preventive physical examination (IPPE) within the past 12 months before the physician is able to bill CCCM services. Though we continue to recognize the clinical value in having Medicare beneficiaries receive AWV and IPPE services, the CMS proposal needlessly creates an obstacle for patients with complex chronic conditions who would immediately benefit from receiving CCCM services. Rather than needlessly limit Medicare beneficiaries' access to the new CCCM services, the AAFP instead urges CMS to simply remove this prerequisite.

CCCM Services Furnished Incident to a Physician's Service under General Physician Supervision

The AAFP supports that CMS proposes to count time spent by clinical staff outside normal business hours even though those services do not meet the direct supervision requirement of "incident to."

However, the AAFP is troubled with the CMS proposal that requires the clinical staff person to be "directly employed by the physician and the employed clinical staff person meets any relevant state requirements." In reality, for many practices, the clinical staff is directly employed by the *practice* rather than the *physician* [emphasis added]. Instead, the AAFP urges CMS to use language in section 60.4 of chapter 15 of the Medicare Benefit Policy Manual that refers to "general physician supervision by employees of the physician or clinic." For CCCM services, the AAFP encourages CMS to consider the entire clinical team of the practice, not just an individual physician.

CCCM Services and the Primary Care Incentive Payment (PCIP) Program

The AAFP concurs with the CMS proposal to exclude CCCM codes from the PCIP denominator for the reasons outlined in the proposed rule. Though the AAFP wishes CMS had the authority to add codes and additional services to the definition of primary care services for purposes of the PCIP, we appreciate CMS' efforts to avoid inadvertently disqualifying community primary care physicians who provide CCMS services on a primary care basis. CMS finalized a policy in 2011 that removed allowed charges for certain E/M services furnished to hospital inpatients and outpatients from the total allowed charges in the PCIP primary care percentage calculation. Earlier this year, CMS adopted a policy that the TCM code should be treated in the same manner as those services for the purposes of PCIP because post-discharge TCM services are a complement in the community setting to the hospital-based discharge-day management services already excluded from the PCIP denominator. Thus, it is logical and the AAFP fully supports the

proposal to exclude CCM codes from the denominator of the primary care percentage calculation so as to not produce unwarranted bias against true primary care physicians who are involved in furnishing post discharge care to their patients.

III.B. Ultrasound Screening for Abdominal Aortic Aneurysm

Currently, Medicare covers ultrasound screening for abdominal aortic aneurysms for a beneficiary who meets certain criteria, including that he or she must receive a referral during the initial preventive physical examination (IPPE) and has not previously had an Abdominal Aortic Aneurysm (AAA) screening covered under the Medicare program. The IPPE includes a time restriction and must be furnished not more than one year after the effective date of the beneficiary's first Part B coverage period. In the proposed rule, CMS argues this time limitation for the IPPE reduces a Medicare beneficiary's ability to obtain a referral for AAA screening.

CMS has authority to modify coverage of certain preventive services to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force (USPSTF). In 2005, the USPSTF recommended with a Grade B a "one-time screening for [AAA] by ultrasonography in men ages 65 through 75 who have ever smoked."

The USPSTF recommendation does not include a time limit with respect to the referral for this test, so CMS proposes to modify coverage of AAA screening consistent with the recommendations of the USPSTF to eliminate the one-year time limit with respect to the referral for this service. This proposed modification would allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the IPPE. The AAFP fully supports this proposal since it improves patients' ability to receive this important preventive screening.

III.C. Colorectal Cancer Screening

Medicare covers colorectal cancer screening via fecal occult blood tests (FOBT), screening flexible sigmoidoscopies, screening colonoscopies, and other tests determined to be appropriate, subject to certain frequency and payment limits.

Current policies were established in 1997 and require a written order by the beneficiary's attending physician. CMS required this written order as a way to ensure beneficiaries receive appropriate preventive counseling about the implications and possible results of having these examinations performed.

Since then, Medicare coverage of preventive services has expanded to cover, among other things, an annual wellness visit which includes furnishing personalized health advice and appropriate referrals. In addition to physicians, the annual wellness visit can be furnished by certain non-physician practitioners, including physician assistants, nurse practitioners, and clinical nurse specialists.

CMS proposes to revise the conditions for coverage of screening fecal-occult blood test policy to allow an attending physician, physician assistant, nurse practitioner, or clinical

nurse specialist to furnish written orders for screening FOBT. CMS believes this proposed modification would allow for expanded coverage and access to screening FOBT, particularly in rural areas, and the agency invites public comment on this proposal and whether a practitioner permitted to order a screening FOBT must be the beneficiary's attending practitioner.

Conceptually, the AAFP supports expanded coverage and access to preventive screening services. The AAFP is comfortable with non-physician practitioners ordering the screening FOBT so long as they "function under the direction and responsible supervision of a practicing, licensed physician," as called for in the AAFP's policy on [Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants](#).

III.E. Proposals Regarding the Clinical Laboratory Fee Schedule

CMS proposes reviewing payments for all of 1,250 services in the clinical laboratory fee schedule (CLFS). Similar to the annual review of physician services, CMS proposes to annually review certain CLFS codes to determine whether the payment amounts are appropriate. Beginning with the 2015 proposed MPFS, CMS would identify and discuss codes impacted by technological changes and propose an associated adjustment to the payment amount. This comprehensive review would begin in 2015 and be conducted over five years, and CMS proposes to review the oldest codes first. CMS estimates that most CLFS services will experience a decline in payment due to efficiencies in technology over time.

Over 90 percent of AAFP members have laboratories within their practice and bill for laboratory services, thus the AAFP is concerned with estimated cuts in future reimbursement. However, the AAFP still supports the proposed process to review and refine CLFS services paid for by CMS. The AAFP suggests CMS create a process for public input before adjustments are proposed to these regulations so that the agency can incorporate provider, manufacturer, payer, patient, and other stakeholder input relative to CLFS codes being reviewed. We believe this public input would better inform subsequent adjustments subject to proposed rulemaking.

III.G. Physician Compare Website

The *Affordable Care Act* requires that CMS develop a Physician Compare website with information on physicians enrolled in the Medicare program as well as information on other eligible professionals who participate in the Physician Quality Reporting System (PQRS). It also requires CMS to implement a plan to make publicly available the information on physician performance on quality and patient experience measures. This June, CMS launched a full redesign of Physician Compare, including a complete overhaul of the underlying database and a new intelligent search feature. Users can now view information about approved Medicare professionals, such as name, primary and secondary specialties, practice locations, group affiliations, hospital affiliations that link to the hospital's profile on Hospital Compare as available, Medicare Assignment status, education, languages spoken, and American Board of Medical Specialties (ABMS) board certification information. In addition, for group practices, users can also view group

practice names, specialties, practice locations, Medicare Assignment status, and affiliated professionals. The AAFP commends the agency for the improvements made in this redesign.

In the 2014 proposed MPFS, CMS discusses intentions to continue to expand the Physician Compare website over the next several years by incorporating quality measures from a variety of sources. For 2014, CMS proposes to expand the quality measures posted on Physician Compare by publicly reporting performance on all measures collected through the Group Practice Reporting Option (GPRO) web interface for groups of all sizes participating in 2014 under the PQRS GPRO and for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. These data would include measure performance rates for measures reported that would meet the minimum sample size of 20 patients and that prove to be statistically valid and reliable.

CMS proposes a 30-day preview period prior to publication of quality data on Physician Compare, so group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported. The AAFP believes this proposed 30-day preview period is too short, especially since physicians would have no advance warning when the 30-day preview period would begin precisely. The AAFP urges CMS to reconsider and to offer a 45-day or 60-day preview period.

CMS also proposes to report publicly on Physician Compare the performance on certain measures that groups report using registries and EHRs in 2014 for the PQRS GPRO. No earlier than 2015, CMS plans to post performance information on the GPRO registry and on EHR measures that can also be reported via the GPRO web interface in 2014. By proposing to include on Physician Compare performance on these measures reported by participants under the GPRO through registries and EHRs, as well as the GPRO web interface, CMS states beneficiaries will see a consistent set of measures over time.

For data reported for 2014, CMS proposes to continue public reporting of Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for PQRS GPRO group practices of 100 or more eligible professionals participating in the GPRO via the web interface and for Shared Savings Program ACOs reporting through the GPRO web interface or other CMS-approved tool or interface. Finally, CMS seeks comment on posting performance on patient experience survey-based measures for individual eligible professionals starting with data collected for 2015.

Overall, the AAFP appreciates the phased and deliberate approach that CMS has taken in implementing these *Affordable Care Act* requirements. Our [policy](#) on “Physician Performance Reporting, Guiding Principles” states our belief that the primary purpose of performance measurement and sharing of the results should be to identify opportunities to improve patient care. To that point, we remain skeptical as to the utility and meaningfulness of PQRS performance information for beneficiaries as consumers. PQRS quality measures (e.g. Coronary Artery Disease: Angiotensin-converting Enzyme (ACE) Inhibitor, Angiotensin Receptor Blocker (ARB) Therapy, or Diabetes or Left Ventricular

Systolic Dysfunction (LVEF < 40%)) are likely to be incomprehensible to a typical non-clinician consumer. To make physician performance information more meaningful, CMS may want to develop a method to aggregate performance on these measures into one or more composite scores that could be easily translated into consumer friendly terms (e.g. Dr. Jones scored 4.5 on preventive care, where “1” is “poor” and “5” is excellent).

III.H. Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) provides incentive payments to identified eligible professionals or group practices who satisfactorily report (via Medicare Part B claims, qualified PQRS registry, or qualified PQRS electronic health record) data on quality measures for covered professional services furnished during a specified reporting period (full and half year options). Payment penalties will apply in the future to those who do not report or do not report satisfactorily. For instance, under current law, CMS will impose a 1.5 percent penalty on practices in 2015 that do not successfully participate in the 2013 PQRS. For those in 2014 who do not successfully participate, the payment penalty would be 2 percent in 2016. The 2014 PQRS is the final year for positive incentive payments under the PQRS.

Within the 2014 proposed MPFS, CMS makes several modifications that are intended to align various quality improvement programs in order to decrease the burden of participation on physicians and allow them to spend more time and resources caring for beneficiaries. For the most part, the AAFP appreciates these efforts. CMS also proposes that if an eligible professional meets the criteria for the 2014 PQRS incentive, doing so will satisfy the reporting for the 2016 PQRS payment adjustment. In other words, eligible professionals who meet the criteria for the 2014 PQRS incentive will automatically avoid the downward payment adjustment for 2016. We appreciate this proposal since it creates more certainty for physicians in regards to avoiding future payment reductions.

Regarding PQRS participation for individual eligible professionals, CMS proposes to increase the number of measures that must be reported via the claims- and registry-based reporting mechanisms from three to nine and for these nine measures to span three National Quality Strategy domains. CMS justifies this increase based on “the need to collect enough quality measures data to better capture the picture of the care being furnished to a beneficiary, especially when this data may be used to evaluate an eligible professional’s quality performance under the value-based payment modifier...” The AAFP suggests that this is not a sufficient justification. It does not explain why nine is required or why three was not sufficient.

The AAFP remains concerned that the burden of reporting multiple quality measures too often falls disproportionately on primary care physicians. Many sub-specialists, for whom fewer than nine measures will apply, will not be subject to the same reporting burdens as primary care physicians, who consistently have more reportable measures. Although the reporting burdens are unequal between primary care physicians and sub-specialists, the incentive payments and penalties remain the same. We strongly object to this arrangement. Furthermore, given the longstanding payment disparities in the Medicare physician payment system, the PQRS incentive payment that primary care physicians

might receive will continue to be significantly less than that for which sub-specialists are eligible. Thus, in regard to the PQRS, CMS is asking primary care physicians to report more measures for less incentive. The AAFP considers this unfair and harmful to primary care, and we therefore strongly urge CMS to explore policies that equalize reporting burdens and incentives across specialties.

CMS also proposes to change the threshold for reporting individual measures via registry to require that eligible professionals report on 50 percent of the eligible professional's Medicare Part B fee-for-service patients rather than 80 percent. We appreciate the reduction in the percentage of patients, especially considering the separate proposal to increase the required number of reported measures.

Though CMS earlier stated a policy preference to harmonize reporting requirements across various incentive programs, CMS nevertheless states, "We understand that the EHR Incentive Program may accept versions of electronically specified clinical quality measures that may be outdated. We propose that for purposes of the PQRS, eligible professionals must report the most recent, updated version of a clinical quality measure." The AAFP sees this as a flawed proposal. Given the move to otherwise align quality measures across CMS programs, if CMS will accept outdated measures for one program, then the agency ought to accept outdated measures for other programs.

In this proposed rule, CMS also asks questions about the future of PQRS reporting periods. Specifically, CMS asks if the agency should, "consider establishing a reporting period that occurs closer to the adjustment year for certain PQRS reporting mechanisms, such as the registry, EHR, and GPRO web interface reporting mechanisms?" The AAFP absolutely supports this approach. Family physicians are already frustrated with the delay between the reporting period and the payment year impacted and any effort to minimize that delay would help evolve the PQRS into an actual quality *improvement* program rather than the current quality *reporting* program. PQRS registries, EHRs, and web interfaces all report electronically; as a result, the AAFP believes there is no reason to justify such long lags between reporting and payment. The closer quality reporting is to the affected payment, the more influence quality reporting will have on improving patient outcomes.

CMS also asks, "Should the reporting periods still be structured as 12-month reporting periods occurring in a calendar year or multiple years? What length of time should be used for the reporting period? For example, should the PQRS allow for shorter, quarterly reporting periods?" The AAFP does not see any meaningful connection between the PQRS and a 12-month reporting period. Quality improvement efforts should occur daily, not within an arbitrary reporting time-frame. To the extent that CMS is able to reduce or shift the reporting period to be closer to the period in which the results have an impact, the AAFP encourages CMS to do so. As long as the reporting period is long enough to allow capture of the necessary, statistically valid data, the AAFP believes reporting periods can be as long or as short as needed. Shorter reporting periods will mean reporting more often, which could increase the burden on physicians.

CMS also asks for public feedback on future plans for the PQRS GPRO. In particular CMS inquires about limiting the definition of group practices to a single tax identification number (TIN). CMS notes that some programs with quality reporting components allow group practices containing multiple TINs to participate in these programs as a single group practice. Given that, the AAFP does not understand why CMS would not allow multiple TINs from multiple group practices to partner together for purposes of being evaluated by CMS for the PQRS. Therefore, the AAFP urges CMS to offer group practices this flexibility.

Regarding satisfactory reporting criteria for group practices using the GPRO web interface, it is clearly problematic and contrary to the principles of quality improvement if a group practice would be able to qualify for the PQRS incentive or avoid the PQRS payment adjustment based on successful reporting for only one beneficiary. Therefore, the AAFP suggests CMS establish a minimum reporting threshold for group practices that use the GPRO interface.

In the 2014 MPFS, CMS discusses the possibility of eliminating claims-based reporting in 2017 for the 2019 penalty. In many ways, for the reasons that CMS outlines, the AAFP agrees with moving away from claims-based reporting. However, although the claims-based reporting method is often problematic, the AAFP reminds CMS that 72 percent of eligible professionals are participating in the 2011 PQRS using a claims-based method. Considering the additional costs associated with reporting via a registry or EHR, the AAFP believes it is unfair for CMS to require practices to invest in reporting methods while payment levels remain stagnant and while practices are forced to invest in the conversion to ICD-10 and other EHR incentive programs. If CMS wants to eliminate claims-based reporting, the AAFP first strongly recommends that CMS require certified electronic health record technology (CEHRT) vendors to offer technology that has the capacity to report all PQRS measures expected by primary care physicians. After all vendors are successful in offering this capacity, only then should the agency begin to gradually phase out claims-based reporting. This requirement will allow practices already comfortable with PQRS claims-based reporting to prepare for newer methods for participating in the PQRS. CMS might consider first phasing out large groups from using claims-based reporting and then eventually eliminate the option for solo and small practices.

CMS also seeks comments on whether feedback reports for the PQRS and value-based payment modifier should be merged. The AAFP unequivocally supports this proposal. Especially considering how burdensome it can be to access CMS feedback reports, family physicians would prefer one comprehensive report. This is administratively simpler for both CMS and physicians and is consistent with the notion of aligning CMS programs.

III.I. Electronic Health Record (EHR) Incentive Program

The AAFP continues to support our members in their journey to achieving meaningful use and earning incentive payments through the Medicare and Medicaid EHR Incentive Programs. Within this rule, CMS proposes an additional option for eligible professionals to report clinical quality measures (CQMs) using “qualified clinical data registries” and fulfill

reporting requirements for the PQRS and Medicare EHR Incentive Program. This new reporting method would require eligible professionals to use certified EHR technology and report CQMs that were included in the EHR Incentive Program Stage 2 final rule.

CMS separately uses a subset of CQMs in the CPCI, and in another effort to align quality reporting programs and innovation initiatives, CMS proposes to add a group reporting option to the Medicare EHR Incentive program beginning in 2014 for eligible professionals who are part of a CPCI practice site that successfully submits at least 9 CQMs covering 3 domains. CMS proposes that each of the eligible professionals in the CPCI practice site would satisfy the CQM reporting component of meaningful use if the practice site successfully submits and meets the reporting requirements of the CPCI.

The AAFP supports this effort to harmonize reporting requirements, yet urges CMS and the Office of the National Coordinator for Health Information Technology (ONC) to also address the AAFP's [increasing concerns](#) with the expectations with Meaningful Use, Stage 2. In summary, to address these concerns, the AAFP recommends CMS and ONC not delay but extend by 12 months the implementation of meaningful use stage 2. If the current plan is left intact, the AAFP is concerned it would outstrip the capacity of many certified electronic health record technology (CEHRT) vendors and ambulatory family medicine practices. Instead, CMS and ONC should use the AAFP's plan to extend the timeline for compliance and create three distinct groups of attesting physicians, and each group would be affected differently by the timeline modification.

III.J. Medicare Shared Savings Program

The Medicare Shared Savings Program is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. CMS proposes changes to this program to further align with the PQRS reporting requirements, and the AAFP supports this effort to harmonize the programs. CMS proposes that ACOs would report through a CMS web interface on behalf of eligible professionals and that the ACOs would have to meet the criteria for the 2014 PQRS incentive to satisfactorily report to avoid the 2016 PQRS payment adjustment. CMS had previously indicated that the agency would use the national Medicare Advantage and FFS Medicare performance data and seek to incorporate actual ACO performance into establishing quality benchmarks for the program. The agency is now proposing to include data submitted by the Shared Savings Program and Pioneer ACOs to set the benchmark for the 2014 performance period. In addition, CMS proposes a method to increase the spread of tightly clustered performance rates in order to continue providing incentives to improve quality and provide achievable benchmarks for newly formed ACOs. Finally, CMS proposes to increase the scoring for the CG-CAHPS survey measure modules within the patient experience of care domain, so that the CAHPS survey measure modules carry greater weight within the patient experience of care domain.

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

The *Affordable Care Act* calls for CMS to establish a value-based modifier that provides for differential payment to a physician or group of physicians under the Medicare

physician fee schedule based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires CMS to begin applying the value-based modifier in 2015, with respect to items and services furnished by specific physicians and groups of physicians, and to apply it to all physicians and groups of physicians beginning not later than January 1, 2017. The statute also requires that the value-base modifier be implemented in a budget neutral manner, meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance.

In 2012, CMS established 2013 as the performance period for the determination of the value-based modifier to be applied in 2015 and proposed to use 2014 as the performance period for the value-based modifier to be applied in 2016. The final 2013 MPFS applies the value-based modifier to groups of physicians with 100 or more eligible professionals in 2015, a change from the 2013 proposed MPFS, which would have set the group size at 25 or above.

In the 2014 proposed MPFS, CMS makes several refinements to the existing value-based payment modifier policies. CMS proposes to apply the value-based payment modifier to groups of physicians with 10 or more eligible professionals in 2016 based on their 2014 performance. Given that the statute requires CMS to apply the value-based modifier to all physicians by 2017, at face value this is not an unreasonable proposal especially given the distribution of groups by size shown by CMS in Table 61 of the proposed rule.

CMS proposes to require quality-tiering for groups within Category 1 for the 2016 value-based payment modifier, except that groups of physicians with between 10 and 99 eligible professionals would be subject only to any upward or neutral adjustment determined under the quality-tiering methodology, and groups of physicians with 100 or more eligible professionals would be subject to upward, neutral, or downward adjustments determined under the quality-tiering methodology.

In general, the AAFP finds this as reasonable and fitting with the statutory mandate. We appreciate that CMS is holding harmless groups of 10-99 eligible professionals, which will be newly added to the mix in 2016 based on their performance in 2014. The AAFP also supports the proposed method for CMS to consider as Category 1 groups whose members still report PQRS as eligible professionals so long as 70 percent of the eligible professionals in the group meet the criteria for satisfactory reporting.

CMS also proposes to increase the amount of payment at risk under the value-based payment modifier from 1.0 percent to 2.0 percent in 2016. CMS states that it can increase “the amount of payment at risk because we can reliably apply a value-based payment modifier in 2016 to groups of physicians with 10 or more eligible professionals and to smaller groups and to solo practitioners in future years.” Curiously, CMS seems to contradict itself in this regard because the proposed rule later states, “However, we noted that as we gained experience with our value-based payment modifier methodologies, we would likely consider ways to increase the amount of payment at risk (77 FR 69324).”

Since CMS has not even yet implemented this program, the AAFP does not understand how the agency already gained sufficient experience to increase the amount of payment at risk. Similarly, the proposal seems to ignore the fact that physicians also have no experience with the program. Rather than prematurely raising the stakes in this regard, the AAFP urges CMS to allow sufficient time for the agency and physicians to gain actual experience before making this change.

The AAFP fully supports CMS proposals to align the quality measures and quality reporting mechanisms for the value-based payment modifier with those available to physicians under the PQRS during the 2014 performance period.

CMS also proposes to include the Medicare Spending Per Beneficiary (MSPB) measure be added to the total per capita costs for all attributed beneficiaries domain of the value-based payment modifier. The AAFP has no objections to including this measure in the cost composite. We like the agency's multiple attribution approach for the reasons outlined in the proposed rule, especially since it emphasizes shared accountability. To that end, extending attribution to services provided at any time during the entire episode (not just the hospitalization) seems like a valid alternative that the AAFP could support. We believe requiring a minimum of 20 episodes is reasonable. That being said, based on the numbers CMS provides in Table 63 of the proposed rule, it appears that lowering that number to 10 would not sacrifice much reliability.

Finally, the AAFP thanks CMS for acknowledging the high value of primary care services through a discussion on value-based modifier feedback reports for physicians. As noted by the agency, "Among high-risk Medicare beneficiaries, visiting a primary care physician during the year was associated with lower costs, but having a physician who is more involved in one's care (that is, the physician directed or influenced care) is associated with the lowest costs, on average."

In closing, 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 "Glen Stream MD". The signature is written in a cursive, slightly slanted style.

Glen Stream, MD, MBI, FAAFP
Board Chair