



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 26, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015" [proposed rule](#) as published by the Centers for Medicare & Medicaid Services (CMS) in the July 11, 2014, *Federal Register*. This AAFP comment letter is in addition to an August 1, 2014, [letter](#) to CMS that focused on proposed changes to Section III.I, Reports of Payments or Other Transfers of Value to Covered Recipients.

The AAFP continues to appreciate that CMS proposes short term payment strategies that recognize primary care and care coordination as critical components in achieving better care for individuals and reduced expenditure growth. However, the proposed fee schedule includes an estimated 20.9 percent reduction to the conversion factor based on the sustainable growth rate (SGR), the statutory formula used to determine Medicare physician payments, unless Congress intervenes before March 31, 2015. The AAFP encourages CMS and Congress to work together and avert this devastating cut and replace it with a formula that includes better payment for primary care.

To improve the final 2015 Medicare physician fee schedule rule, in summary the AAFP:

- Urges CMS to create separate primary care E/M codes for office or other outpatient services to new and established patients with correspondingly higher relative values.
- Thanks CMS for identifying that Chronic Care Management (CCM) services for beneficiaries with multiple chronic conditions are not adequately reflected in the existing evaluation and management codes, however, the AAFP expresses several concerns with the proposal and we especially urge CMS to consider phasing in the required use of an electronic care plan.
- Continues to encourage 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 ones, such as the inpatient, outpatient, or ambulatory surgical center settings.

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- Appreciates and supports CMS' efforts to identify and review potentially misvalued codes. However, we also feel more can be done to ensure that Medicare is paying appropriately for primary care physician services.
- Supports CMS' proposals regarding how to improve the valuation and coding of the global surgical package.
- Fully supports the CMS' proposal to add codes to the list of covered Medicare telehealth services.
- Supports additional transparency and comment opportunity in the valuation of physician services.
- Strongly disagrees with the CMS proposal to delete the "Continuing Education Exclusion".
- Supports the Physician Compare concept though also has concerns with ensuring that what CMS publishes is actually useful to consumers.
- Supports efforts to align measures across quality programs but is concerned with proposal of adding two cross-cutting measures.
- Appreciates that CMS is holding solo and small group practice physicians harmless in the quality-tiering process since 2017 will be the first year they are subject to the value-based modifier.

II.A Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Citing a desire to better understand the growing trend toward hospital acquisition of physician offices and how subsequent treatment of those locations as off-campus provider-based outpatient departments affects payments under the physician fee schedule, CMS proposes to create a Healthcare Common Procedure Coding System (HCPCS) modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. This reporting requirement would be effective beginning January 1, 2015.

According to CMS, the requirements for a determination that a facility or an organization has provider-based status are specified in 42 CFR 413.65, and the agency defines a hospital campus to be the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office.

The AAFP continues to advocate for bringing more equity in payment across sites of service, and therefore, we support CMS' intent in this area. Our [letter](#) to CMS in response to the proposed 2014 Medicare physician fee schedule concurred with the Medicare Payment Advisory Commission (MedPAC) recommendation 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. This letter also encouraged CMS to consider site-of-service payment parity policies from the opposite perspective. Namely, CMS should not pay significantly more for services in the outpatient setting or Ambulatory Surgical Center (ASC) than in the physician's office. The AAFP continues to encourage 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 ones, such as the inpatient, outpatient, or ASC settings.

However, requiring that a new HCPCS modifier be reported with every CMS-1500 claim form for physicians' services and the corresponding form for hospital outpatient claims for services furnished in an off-campus provider-based department of a hospital beginning in 2015 is a significant change in coding practices for all providers. More importantly, we believe this approach is ill-conceived, and we strongly urge CMS to provide alternatives. Many family physicians work in practices that are owned by a hospital or health system yet are still providing services in the least costly location. The AAFP is concerned these practices will not know about this new requirement, or if they do, might think it does not apply to them under the assumption that their practice is not "provider-based" from CMS' perspective. We believe the CMS requirements in this proposal are not clear or simple. What would CMS do if a practice failed to report the required modifier? How would the agency know if a physician or practice failed to report the required modifier? If CMS is unable to identify these practices, why should anyone go to the trouble of reporting a modifier that does not impact either coverage or payment? If CMS can identify practices that fail to report the modifier, why is the modifier even needed?

Rather than finalize these proposals, instead the AAFP calls on CMS to identify services provided in an off-campus, provider-based setting based on receipt of a corresponding claim for a facility fee from the provider. Doing so would prevent new documentation requirements for providers and also allow CMS contractors to identify off-campus, provider-based settings using existing mechanisms.

Despite our concerns with the proposed approach, the AAFP stands ready to assist CMS in understanding and addressing site-of-service payment discrepancies.

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

The AAFP continues to appreciate and support CMS' efforts to identify and review potentially misvalued codes. However, we also feel more can be done to ensure that Medicare is paying appropriately for primary care physician services rather than paying based on biased data that further exacerbates the undervaluation of primary care services. We therefore encourage CMS to continue this important work.

In this context, we urge CMS consider the innovative primary care physician payment recommendations outlined in our August 29, 2013 [letter](#) sent in response to the proposed 2014 Medicare Physician Fee Schedule. We continue to argue 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 continue to recommend that CMS create separate primary care E/M codes for office or other outpatient services to new and established patients with correspondingly higher relative values. Adopting these primary care physician payment recommendations should begin to help address the looming shortage of primary care physicians and improve the delivery of healthcare in America by encouraging more medical students to enter family medicine and other primary care specialties. The AAFP believes that producing more family physicians helps develop economic growth and address the clinical needs of the influx of patients receiving insurance through Medicare, Medicaid, Children's Health Insurance Program, federal Health Insurance Marketplaces, and private insurers.

Review of High Expenditure Services across Specialties with Medicare Allowed Charges of \$10,000,000 or More

CMS identifies 64 high expenditure services as potentially misvalued. Among them is code 96372, "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular." According to 2013 Medicare claims data, family physicians were the most frequent provider of this service.

This code and others identified by CMS will be considered by the Relativity Assessment Workgroup of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in September. In conjunction with other interested specialties, we have reviewed code 96372 in preparation for the RUC meeting. Upon review, we do not believe the service to be misvalued. From our perspective, there have not been any fundamental changes in the service or how the procedure is performed since it was last reviewed in 2004.

We note that when the RUC reviewed other administration codes (i.e., 96365, 96366, 96367, and 96368) in January 2013, the committee did not recommend any changes to the physician work relative value units (RVUs) to CMS. Also, the RUC made only minimal changes in the practice expense values that it recommended to CMS. Further, we note that the current work RVUs assigned to 96372 (0.17) are in line with other injection procedures. For instance, code 90471, "Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)," also has 0.17 work RVUs.

For these reasons, we encourage CMS to remove code 96372 from its list of potentially misvalued services.

Obesity Behavioral Group Counseling

Regarding the proposal to create two new HCPCS codes for the reporting and payment of group behavioral counseling for obesity, CMS proposes one code would be for groups of 2-4 patients while the other would be for groups of 5-10 patients. Each code would cover 30 minutes of counseling, and no changes are proposed in the coverage criteria for obesity counseling. CMS assumes the typical number of patients in each group will be 4 and 9, respectively, and the agency proposes work and practice expense (PE) values for each code that would net approximately the same number of RVUs as seeing one patient for the same amount of time, based on the assumed number of typical patients in the group. The AAFP agrees with CMS that if a physician is counseling one person or 10, the work per minute is likely to be the same and the PE inputs are unlikely to vary significantly. However, we question how many patients are typically in a group. Given the ranges in the codes, a number closer to the midpoint of each range (thus 3 and either 7 or 8) would make more sense. Therefore, the AAFP asks CMS to lower its assumptions regarding the typical number in the group and consequently increase the RVUs for each code.

Improving the Valuation and Coding of the Global Surgical Package

CMS proposes to transform all 10- and 90-day global codes to 0-day global codes beginning in 2017 with a transitional period. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure.

Since the AAFP sent CMS a February 20, 2013, [letter](#) on this subject, the AAFP especially appreciates CMS' proposals regarding how to improve the valuation and coding of the global surgical package. We agree with the concerns expressed by CMS in this section that the practice of medicine as it relates to surgery and post-operative care is certainly different than when many of the global surgical codes were established decades ago. The AAFP has longstanding concerns that the current codes are not updated regularly based on actual cost or utilization data. Like CMS and the Office of Inspector General (OIG), the AAFP questions the accuracy of current assumptions underlying 10- and 90-day global codes. Also like CMS, we are inclined to think that the current arrangement leads to unwarranted payment disparities and appreciate that the agency highlights the disparity in PE values between Evaluation and Management (E/M) services in a global surgical package and stand-alone E/M services.

Furthermore, the AAFP has long argued the current packages are incompatible with current practice and provide unreliable building blocks for new payment methodologies. We believe 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. Under current Medicare payment rules, such visits would be paid at a discounted rate if reported separately by the NPs and PAs (assuming "incident to" rules were not met); however, these visits are valued at the full physician rate in the global surgical package, even when the visits take place in a hospital (where "incident to" does not apply).

The AAFP therefore fully supports CMS' proposal to transition all 10- and 90-day global periods to 0-day global periods with all deliberate speed. We agree with CMS that this proposed change would:

- Increase the accuracy of physician fee service payment by setting payment rates for individual services based more closely upon the typical resources used in furnishing the procedures;
- Avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period;
- Eliminate disparities between the payment for E/M services in global periods and those furnished individually;
- Maintain the same-day packaging of pre- and post-operative physicians' services in the 0-day global; and
- Facilitate availability of more accurate data for new payment models and quality research.

The AAFP reminds CMS that when the agency re-valued the stand-alone E/M codes in 2007, the agency also made a concurrent adjustment in the value of all of the 10- and 90-day global surgical codes in existence at the time. These concurrent adjustments were based on a CMS-assumed number and level of post-operative visits included in each code. Thus, CMS has de facto valued each of those codes by adding the RVU of the surgical procedure and all pre- and post-operative E/M services included in the global period rather than by magnitude estimation. Accordingly, CMS could begin its transition by reducing the work RVUs by the exact amount of the corresponding stand-alone E/M codes assumed to be included, based on what CMS did in 2007. Due to the vagaries of the RUC process and

the physician fee schedule, it is possible that this approach may leave some codes with negative work RVUs or create obvious rank order anomalies within families. The AAFP believes CMS and the RUC should deal with those exceptions on a case-by-case basis, and CMS should not let the likelihood of such exceptions deter it from systematically making the proposed transition on the timeline proposed.

Additionally, the AAFP notes that the work RVU is a direct input to both the PE RVU as well as the malpractice RVU in the methodologies that CMS uses for each. Thus, CMS also will need to adjust the PE and malpractice RVUs for all of these codes to account for both the decline in the work RVU as well as the elimination of follow-up clinical labor, supplies, and equipment associated with the E/M services in question.

CMS seeks comments on “the most efficient means of acquiring accurate data regarding the number of visits and other services actually being furnished by the practitioner during the current post-operative periods.” CMS also states, “We acknowledge that collecting information on these services through claims submission may be the best approach, and we would propose such a collection through future rulemaking. However, we are also interested in alternatives.”

The AAFP does not believe a claims-based approach will be effective since it is illogical to require surgeons to report codes on claims that will not be paid (because they’re part of the global surgical package). Second, it will not validate that the services being reported are accurately reported. As CMS noted in the preamble to the proposed rule on the 2013 Medicare physician fee schedule, “The OIG could only review the number of face-to-face services and was not able to review the level of E/M services that the surgeons furnished *due to a lack of documentation in the surgeons’ medical records.*” (Emphasis added) Any such data collected under these circumstances would be inherently unreliable. Surgeons could fail to report because they have never had to do so and because it would not impact payment. Alternatively, surgeons could become more scrupulous about providing, documenting, and reporting post-op E/M services merely because they now know CMS is observing them more closely.

Instead, CMS should take the systematic approach the AAFP suggests and only address the exceptions and anomalies rather than every 10- and 90-day global code. The number of exceptions and anomalies may be sufficiently manageable that CMS can simply do what the OIG has done in its studies and examine the documentation of a statistically valid number of instances of a service (provided before CMS made this proposal) to determine what the actual number and level of related post-operative visits were.

CMS further states, “We also seek comment on the best means to ensure that allowing separate payment of E/M visits during postoperative periods does not incentivize otherwise unnecessary office visits during post-operative periods.” The AAFP encourages CMS to apply the same means that it uses with E/M services currently billed separately. In other words, the AAFP believes E/M visits billed during a postoperative period should be subject to the exact same screens, edits, and documentation guidelines currently applied to all other E/M services.

Later in the proposed rule CMS states, “We also seek comment regarding the appropriate valuation of new, revised, or potentially misvalued 10- or 90-day global codes before implementation of this proposal.” In light of the proposal, the AAFP believes CMS ought to

do one of two things; namely, simply convert new, revised, or potentially misvalued global surgical codes to 0-day globals at the point that they come up for (re)valuation, or alternatively, the agency could value them using a building block approach, so that it is very clear what the agency needs to remove when the transition is implemented.

II.E. Medicare Telehealth Services

CMS proposes to add the following services to the 2015 Medicare approved telehealth services list:

- Annual wellness visit HCPCS codes G0438 and G0439
- Psychotherapy services CPT codes 90845, 90846 and 90847
- Prolonged service office CPT codes 99354 and 99355

The AAFP fully supports the CMS' proposal to add these codes to the list of covered telehealth services for the reasons that CMS cited. With respect to the codes to which CMS did not extend telehealth coverage, the AAFP agrees with the rationale in each case.

II.F. Valuing New, Revised and Potentially Misvalued Codes

To respond promptly to the call for greater transparency in the valuation process, CMS proposes a modified review for new, revised, and potentially misvalued services that would begin with the 2016 Medicare physician fee proposed rule.

The AAFP supports additional transparency and comment opportunity in the valuation of physician services. The AAFP and 70 other national physician organizations sent CMS a [letter](#) on August 13 with our recommendations related to this particular proposal, and we urge CMS to carefully review this letter as the agency prepares the 2015 final rule.

II.G. Chronic Care Management

Before proposing policy surrounding the chronic care management (CCM) code, CMS first reiterates a commitment to supporting primary care and lists a series of initiatives designed to improve payment for, and encourage long-term investment in, care management services. The AAFP sincerely thanks CMS for these continued efforts since we believe more appropriate payments for family physicians are critical in achieving better care for individuals, better health for individuals, and reduced expenditure growth.

We also thank CMS for identifying that CCM services for beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes, and we therefore support CMS' proposal to pay CCM services in 2015. Furthermore, we appreciate the agency's recognition of the value of non-face-to-face services provided by primary care physicians and their staff in support of beneficiaries with chronic conditions.

However, the AAFP still has several concerns with the proposal and we offer the following suggestions.

Valuation

Since CMS is wisely exploring several efforts to reimburse for chronic care and transitional care management services both in fee for service and through the CPC initiative, the AAFP urges CMS to move quickly and create a risk-adjusted, per-patient per-month (PPPM) care management fee approach and then phase out this initial and proposed fee-for-service approach. However, the AAFP does not object to CMS not allowing physicians in the CPC initiative or Multi-payer Advanced Primary Care Practice demo to bill the new CCM code for

any beneficiary attributed to the practice for purposes of participating in one of these initiatives, since they are already earning a PPM care management fee. We understand that these physicians may still bill Medicare for CCM services furnished to eligible beneficiaries who are not attributed to the practice for the purpose of the practice's participation as part of one of these initiatives.

To that end, we urge CMS to review and utilize the AAFP's "Care Management Fee" [policy](#), since the AAFP believes care management is better handled as a PPM fee rather than fee for service under a blended payment model. This policy was adopted at the AAFP's July 2014 board meeting:

Care Management Fees

During the past few decades, family physicians increasingly have been challenged to transform the way they deliver care to their patients while still participating in a traditional fee-for-service (FFS) payment environment. However, substantial transformations in health care delivery systems can only be effective if accompanied by the adoption of innovative payment models.

One innovation that is growing in popularity is the blended payment model. In this model, a practice functioning as a patient-centered medical home (PCMH) is paid a combination (i.e., a "blend") of enhanced FFS payment, incentives for quality performance, and a per member per month (PMPM) care management fee to cover care that falls outside of the traditional office visit.

The term "care management" refers to activities performed by health care professionals with a goal of facilitating appropriate patient care across the health care system. In order to increase patient satisfaction and improve outcomes (e.g., greater adherence to treatment recommendations; more effective self-management; improved health and wellness), care management programs provide services that typically are not reimbursed under traditional, FFS payment models. These services include patient education; medication management and adherence support; risk stratification; population management; and coordination of care transitions.

The PMPM care management fee is not intended to defray start-up costs associated with implementing a care management program, nor to provide payment to practices for improved outcomes and/or savings that result from their care management efforts. Such additional payments are an important part of a blended payment model; however, they are distinct from reimbursement for care management services.

The American Academy of Family Physicians (AAFP) considers the following seven elements to be core activities covered by a PMPM care management fee within the context of a PCMH.

ELEMENT 1: Nonphysician staff time dedicated to care management

Nonphysician staff can range from a full-time care manager who oversees all care management activities in the practice to part-time staff members who provide one-on-one care management and support to an assigned panel of patients. Patient support can be provided on site or remotely (e.g., via telephone or videoconferencing). Staff members who dedicate time to care management may not necessarily be employees of the practice or work at the practice location. Although many advocates emphasize the

need for highly educated care management staff—preferably registered nurses or nurse practitioners—the optimal level of education and prior experience for a care manager is still undefined.

ELEMENT 2: Patient education

Health care professionals provide patient education to promote health literacy (i.e., the ability to understand health-related information and use it to make appropriate decisions about one's health). Regularly scheduled learning sessions and group visits are examples of innovative approaches that care management programs use to engage patients, broaden patients' knowledge base, encourage behavior change, and teach self-management skills.

ELEMENT 3: Use of advanced technology to support care management

Technology enables practices to provide care management for their patients outside of the traditional face-to-face office visit. Advanced communication tools (e.g., secure email, audio, video, web portals) enable more frequent and timely exchange of information between the patient and the care management team. Patients use in-home electronic devices (e.g., blood glucose meters, weight scales, blood pressure monitors) to collect real-time clinical information that is relevant to managing their care. Telemonitoring devices and services enable patients to transmit information about their vital signs, symptoms, and behaviors (e.g., blood pressure levels, blood glucose levels, exercise logs, medication schedules) directly to their care management team.

ELEMENT 4: Physician time dedicated to care management

Many physicians already spend a substantial amount of time engaged in non-face-to-face care management (e.g., communicating with other health care professionals who provide care for their patients). In addition, physicians often lead or supervise care management services provided by other staff members on the care management team.

ELEMENT 5: Medication management

Each patient participating in a care management program should have an individual medication plan. One aspect of a care manager's role is to provide education and support to ensure that each patient is capable of adhering to his or her medication plan.

ELEMENT 6: Population risk stratification and management

Care management programs use risk-stratification tools to predict patients' health care needs and recommend appropriate preventive services and/or chronic care management. These tools take into account information such as a patient's self-identified health risks, clinical diagnoses, and utilization data from payers (if available). Electronic health records and disease registries allow practices to monitor the provision of recommended care for each patient on an ongoing basis.

ELEMENT 7: Integrated, coordinated care across the health care system

Integrating other elements of health care (e.g., subspecialty care, home health care, inpatient and outpatient hospital care, behavioral health services) with primary care services is essential for the success of a care management program. A care management program provides the foundation for effective communication, coordinated treatment, and well-managed care transitions across the "medical neighborhood" to optimize the quality of patient care and reduce unnecessary utilization. These efforts are

facilitated by electronic health information exchanges, clinical registries, telehealth and/or telemedicine, and direct communication among health care professionals.

If CMS is not willing or yet able to pay a PPPM fee, then the AAFP advocates that CMS recognize and pay the existing CPT codes, 99487 and 99489. Doing so would seem to eliminate the need for yet another G code. The CPT codes allow for add-on codes, so primary care physicians can bill for outliers in terms of beneficiaries that require significantly more than the typical time per month, which cannot be easily accounted for otherwise under CMS' proposal.

Finally, should CMS not pay the PPPM fee or recognize and pay the existing CPT codes, at the very least CMS should make the following adjustments to its G-code proposal. First, the G-code descriptor refers to "20 minutes or more," but it does not specify whether this is physician time or clinical staff time. It seems clear from the preamble that this is intended to be clinical staff time; if so, we urge CMS to specify as such in the descriptor.

Second, CMS proposes that its G-code will include only 20 minutes of clinical labor time as a direct PE input. Since CMS proposes neither an add-on code nor any risk adjustments, CMS will be underpaying on practice expense for every patient who receives more than 20 minutes of CCM, which is the minimum referenced in the proposed code descriptor. The AAFP urges CMS not to incentivize minimalist care in this regard. Given the open-ended nature of the code (20 minutes or more), the AAFP believes CMS needs to include more than 20 minutes of clinical staff time in the direct PE inputs for the code. For instance, the CPT Editorial Panel has created a new code, 99490X, for 2015 similar to what CMS has proposed. Like the proposed G-code descriptor, the new CPT code descriptor references "at least 20 minutes of clinical staff time." However, when the RUC reviewed the code in April, the committee arrived at a recommendation of 60 minutes of registered nurse time as a direct PE input for this service, recognizing that the typical amount of clinical labor time involved would be greater than the minimum that is described by the code. In this instance, the AAFP urges CMS to follow the RUC recommendation of 60 minutes of clinical labor time as a direct PE input, even if CMS insists on having just one code to cover 20 minutes or more of CCM per month based on clinical staff time. In any case, it is our understanding that the time spent on CCM is not limited to face-to-face time with the patient.

Another concern the AAFP has with the current proposal is that a "one-size-fits-all" code is not practical for the wide variety of Medicare beneficiaries with multiple chronic conditions. Under its currently proposed payment amount, the G-code may only support disease management, but not care coordination. We believe either the language describing the work in the G-code should be changed to represent protocol driven work and protocol driven care plans with general supervision of clinical staff, or the value needs to be higher to support the actual work of care coordination as surveyed and presented at the RUC.

Health Information Technology Requirement

Another major barrier to widespread utilization of the CCM code is the CMS proposal to require use of a certified (to at least 2014) electronic health record technology (CEHRT) and the required use of an electronic care plan. Though the AAFP supports use of interoperable health information technologies, this proposal significantly limits the number of primary care practices that can offer the CCM service, thus limiting the number of Medicare beneficiaries who could access CCM services. Family physicians that have not adopted an EHR into their practice are able to manage their patients' multiple chronic conditions, and the AAFP

believes CMS should recognize and reimburse these important efforts. Furthermore, many physician and hospital EHRs are not yet interoperable, so this proposed requirement would be of limited value. Since chronic care management services can be performed without an EHR and since requiring an EHR would severely limit the utilization of the CCM code, the AAFP urges CMS not to require an EHR in order to bill the CCM code. At the very least, we strongly urge CMS to consider phasing in the required use of an electronic care plan, since even in advanced primary care practices, a very limited percentage have yet to include a care plan embedded in their electronic medical records. Even those practices that do have an electronic care plan embedded indicate a lack of the capability to include patient values and priorities. Current EHRs, including those that are CEHRT 2014 edition, are lacking the functionality to support electronic care plans and still have not proven their ability to be interoperable. Physicians depend completely on their EHR vendor to provide the needed functionality to support any of these new or improved capabilities of CCM. CMS, in considering payment amounts and timelines, must take into account this dependence and the additional resources physicians must deploy to comply with these additional requirements.

Additional Comments

The AAFP fully supports the proposals related to CCM and transitional care management (TCM) services furnished “incident to” a physician’s service under general supervision.

Especially since CMS allows rural health clinics (RHCs) and federally qualified health centers (FQHCs) to bill the TCM service, the AAFP strongly urges CMS to include in the final rule a mechanism for RHCs and FQHCs to bill for CCM services.

In conclusion, the AAFP supports CMS reimbursing for CCM services on fee-for-service basis only as a short-term, transition strategy until CMS is able to expand the ability for all family physicians to receive a PMPM care management fee as they do now under the CPC initiative. In any case, the care management fee should cover the costs of dedicated staff time, physician time, and advanced technology to provide ongoing patient education, risk stratification, population management, medication management and adherence support, and coordination of care transitions. Although additional research is required to determine the most effective and efficient way to implement each care management element in a patient-centered medical home (PCMH), the AAFP believes that a successful care management program incorporates these essential elements. As blended payment models continue to evolve, additional core elements may be identified.

III.D. Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Visits

To provide RHCs and FQHCs with as much flexibility as possible to meet their staffing needs, CMS proposes to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC and, instead, allow nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs. The AAFP finds that to be a reasonable proposal and supports its adoption as part of the final rule on the 2015 physician fee schedule.

III.I. Reports of Payments or Other Transfers of Value to Covered Recipients

The AAFP commented on this specific section in a separate [letter](#) sent to CMS on August 1, 2014. To reiterate, the AAFP strongly disagrees with the CMS proposal to delete the “Continuing Education Exclusion” found in 42 CFR 403.904(g) in its entirety, and we believe

the suggested change would create more confusion and more unintended and unwanted consequences than it purports to resolve.

III.J. 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. CMS proposes to expand public reporting of group-level measures by making all 2015 Physician Quality Reporting System (PQRS) group practice reporting options (GPRO) measure sets across the GPRO web interface, registry, and electronic health record (EHR) reporting mechanisms available for public reporting on Physician Compare in 2016 for groups (2 or more EPs).

Like CMS, the AAFP is concerned with including too much information online about quality measures that an average patient does not well understand. This may negatively impact a consumer's ability to make an informed medical decision. The AAFP appreciates that CMS recognizes this dilemma, and we encourage the agency to avoid that outcome by including only the most important information about the physician as well as including educational products targeted at patients visiting the website.

CMS proposes to give group practices a 30-day preview period before the measures are published on Physician Compare. This time frame is too brief; instead, the AAFP urges CMS to provide a preview period of 90 days to give the physician sufficient time to review, validate, and potentially appeal the finding before public reporting.

CMS also seeks comments on creating composites using 2015 data and publishing composite scores in 2016. The AAFP reviewed the proposal, and we find it preferable to publishing a plethora of individual measures. We agree that the use of benchmarks are necessary and helpful for consumers to make sense from all of the measurement data reported.

In sum, we are supportive of the Physician Compare concept. Our concern comes with ensuring that what CMS publishes is actually useful to consumers. In this regard, a smaller set of composite quality and consumer experience measures with statistically valid benchmarks is preferable to a myriad of individual measures that vary from physician to physician. CMS seems mindful of this concern in the proposed rule, and AAFP is prepared to work with the agency to address this concern going forward.

III.K. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). CMS proposes that EPs and group practices who do not satisfactorily report PQRS quality measures receive a two percent payment reduction under Medicare in 2017 based on data reported in 2015. Since 2014 is the last year to earn a bonus in the PQRS, incentive payments will no longer be available in the 2015 program. Within this regulation, CMS proposes to:

- Require reporting on at least two cross-cutting measures if using a qualified registry;
- Extend the deadline for qualified registries to report to CMS to March 31;

- Require reporting on at least three outcome measures (if available) when reporting with a qualified clinical data registry (QCDR); and
- Move up the deadline for a group practice to register to participate in GPRO from September 30 to June 30.

The AAFP supports efforts to align measures across quality programs but is concerned with proposal of adding two cross-cutting measures, apparently bringing the required total to report to eleven measures. We remain concerned that the burden of reporting multiple quality measures too often falls disproportionately on primary care physicians.

The AAFP supports efforts to group quality measures among specialty type to aid physicians in determining which measures best fit their practice. However, the available list should be used as a guide, not a requirement for reporting. Furthermore, the AAFP supports complete alignment of measure specifications across quality programs to reduce the burden of reporting on family physicians.

The AAFP agrees with the proposal that all measures must undergo the National Quality Forum (NQF) endorsement process before acceptance into PQRS. Family physicians often are involved in the measure development, evaluation, and endorsement process of NQF. The AAFP agrees with the proposal to allow more frequent submissions of data for the PQRS program. Allowing additional opportunities for data submission will allow family physicians to determine the appropriate time that best suits their practice volume.

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

Regarding the EP's or group practice's ability to provide additional information to assist in the informal review process for the EHR incentive program, CMS proposes to limit resubmission to third-party vendors, because the agency believes that third-party vendors are able to detect errors more easily than direct users can. While that may be true, the AAFP is surprised CMS did not further expound on what would then occur if the EHR vendor finds an error. We urge CMS to specify these next steps within the final rule. In addition, the AAFP urges CMS to also allow direct users to resubmit additional information to assist in the informal review process. We have seen how a lack of an appeal process has already harmed our members in the EHR incentive program.

CMS also proposes that, beginning in 2015, EPs would not be required to ensure that their certified EHR technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the CQMs. The AAFP supports this direction but urges CMS to specify that the EP should be held harmless if they make a reasonable attempt to report the most recent version.

III.M. Medicare Shared Savings Program

The AAFP reviewed CMS' proposals to better align the Medicare Shared Savings Program with meaningful use group reporting requirements and to refine the quality measures used in establishing quality performance standards. Insofar as the AAFP continues to support the alignment of overlapping reporting requirements for physicians, we find this alignment proposal to be consistent with AAFP advocacy, and therefore, we support this proposal.

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

The AAFP appreciates the agency's ongoing efforts to implement a provision in the *Affordable Care Act* that calls for CMS to establish a value-based modifier (VM) 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. The law requires CMS to begin applying the VM 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 VM 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.

Within the 2015 proposed Medicare physician fee schedule, CMS would apply the VM to all physicians and nonphysician eligible professionals (EPs) starting in 2017 in accordance with the statutory language. We appreciate that CMS is using discretion and will begin to apply the VM to nonphysician EPs in 2017, especially since CMS already counts nonphysician practitioners when determining group size under the VM.

CMS also proposes to make quality-tiering mandatory for groups and solo practitioners within Category 1 for the 2017 VM. Category 1 includes:

- Groups that meet the criteria for satisfactory reporting of data on PQRS quality measures via the group practice reporting option (GPRO) for the 2017 PQRS payment adjustment;
- Groups that do not register to participate in the PQRS as a group practice participating in the PQRS GPRO in 2015 and that have at least 50 percent of the group's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the 2017 PQRS payment adjustment; and
- Solo practitioners that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the 2017 PQRS payment adjustment.

However, groups with between 2 and 9 eligible professionals and solo practitioners would be subject only to any upward or neutral adjustment determined under the quality-tiering methodology. Groups with 10 or more eligible professionals would be subject to upward, neutral, or downward adjustments determined under the quality-tiering methodology.

The AAFP reviewed these proposals and find them reasonable and consistent with the phased-in approach to implementation that the agency has taken relative to what the law requires. Since 2017 will be the first year in which solo and small group practice physicians are subject to VM, the AAFP appreciates that CMS is holding them harmless in the quality-tiering process.

Furthermore, CMS also proposes to apply the VM to physicians and nonphysician EPs participating in the Shared Savings Program, the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care (CPC) initiative, or other similar Innovation Center models or CMS initiatives starting in 2017. Though the law requires this, the AAFP remains concerned that applying the VM to participants in these initiatives creates a level of "double-jeopardy", since these EPs are already committing themselves to quality reporting and putting themselves at some financial risk by virtue of their participation in the listed initiatives.

The AAFP supports the proposal that clarifies the exclusion of nonassigned claims for non-participating providers from the VM.

However, the AAFP believes it is premature for CMS to increase the amount of payment at risk under the VM from 2.0 percent in 2016 to 4.0 percent in 2017. Since CMS and physicians lack any actual experience with the program, because 2015 will be the first year that VM is applied to anyone, and since it will not be until 2017 that everyone is affected, the AAFP believes it would be more prudent for CMS to fully implement the program and then tinker with the amount of payment at risk rather than increasing the potential penalty at this point in time. As CMS notes, the law does not specify the amount of payment that should be subject to the adjustment, so we believe that CMS does have discretion in this aspect. The AAFP therefore encourages CMS to refrain from making any changes in the amount of payment at risk at least until 2018.

Also, mathematically, the AAFP questions if the difference would change the upward payment adjustments from +1.0x and +2.0x to +2.0x and +4.0x, respectively. Either way, those who are high quality/low cost will get twice as much as those who are average quality/low cost or high quality/average cost. All CMS' proposal does is change the size of "x," which will decrease accordingly, since the total upward payment adjustments must equal the total downward payment adjustments.

CMS also proposes to align the quality measures and quality reporting mechanisms for the VM with those available to groups and individuals under the PQRS during the 2015 performance period. The AAFP finds CMS' alignment proposal to be consistent with AAFP advocacy, and therefore, we support this proposal.

This regulation also proposes to expand the current informal inquiry process to allow additional corrections for the 2015 payment adjustment period. This expanded informal inquiry process establishes an initial corrections process that would allow for only limited corrections. Under this initial corrections process, for the 2015 payment adjustment period, CMS proposes to establish a deadline of January 31, 2015 for a group to request correction of a perceived error made by CMS in the determination of its 2015 VM payment adjustment. Alternatively, CMS seeks comment on a deadline of no later than the end of February 2015, to align with the PQRS informal review process. The AAFP supports the February 28, 2015, deadline. As noted, it aligns with the PQRS informal review process. Also, with the 14-day payment floor, physicians will not know with certainty until January 15 or later whether or not they are truly subject to a negative payment adjustment under VM. Therefore, a January 31, 2015, deadline provides only about two weeks to request correction. We think physicians deserve more time in this regard.

Starting with the 2016 payment adjustment period (which has a performance period of 2014), CMS proposes to continue the expanded informal inquiry process. However, CMS proposes to establish a 30-day period that would start after the release of the Quality and Resource Use Report (QRUR) for the applicable performance period for a group or solo practitioner to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period. Consistent with AAFP [policy](#) on "Physician Performance Reporting, Guiding Principles," the AAFP advocates for a minimum of 90 days for physicians to review, validate, and appeal their payer's performance report.

In response to concerns from the National Quality Forum (NQF), CMS proposes to make modifications in its two-step attribution method as it relates to per-capita cost measures. One modification is to move nurse practitioners (NPs), physician assistants (PAs), and clinical nurse

specialists (CNSs) from Step 1 to Step 2 and thus consider them in the same context as primary care physicians rather than as non-primary care physicians. The agency's rationale is that "we agree that it is appropriate to include NPs, PAs, and CNSs in Step 1 of the attribution method insofar as they provide primary care services." The AAFP opposes this modification since nonphysician practitioners are not primary care physicians. While some may provide some primary care services (which CMS defines as E/M visits in the office, other outpatient, skilled nursing facility, and home settings), so do other specialists (Step 2). However, that doesn't make any of them primary care physicians. Also, many NPs, PAs, and CNSs work in non-primary care settings (e.g., surgeons' offices). If CMS cannot distinguish nonphysician practitioners by primary versus non-primary care settings, we believe it is a mistake and completely arbitrary to treat them all as if they were in primary care settings. Therefore, the AAFP encourages CMS to leave nonphysician practitioners within Step 2.

Also, for both Step 1 and Step 2, CMS determines plurality of primary care services as measured by allowed charges, rather than allowed services. In any case, that favors physicians/groups using upper level E/M codes (which have higher allowed charges). Theoretically, a patient could have a majority of his encounters with Dr. A but be attributed to Dr. B, because Dr. B tends to charge higher level codes for his visits. The AAFP strongly encourages CMS to attribute patients to whom he or she sees most often in accordance with the plain meaning of "plurality of primary care **services**" (emphasis added). Focusing on allowed **services** rather than allowed charges would more accurately attribute patients to a primary care physician based on whom they see most often; this approach is more consistent with the definition of primary care as continuous and comprehensive in nature. Thus, AAFP believes CMS should use allowed **services** in determining the plurality of primary care services for both Step 1 and Step 2.

CMS also proposes to include in its calculation of total per capita cost for Medicare fee for service patients those beneficiaries who are newly enrolled to Medicare during the performance period and enrolled in both Part A and Part B while in Medicare fee for service. CMS would continue to exclude beneficiaries who were in a Medicare Advantage plan part of the year or who were not enrolled in either Part A or Part B for part of the year. Though the AAFP sees no problems with including the newly enrolled, we did not fully understand CMS' rationale for continuing to exclude other beneficiaries who are "part timers." We do not understand what difference it makes why a beneficiary was not in fee for service for part of the year. Put another way, if the agency can impute the costs for one kind of beneficiary, why not the other? The AAFP encourages CMS to expound on this issue within the final 2015 rule.

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

Sincerely,

A handwritten signature in black ink, appearing to be "J. Cain", with a long horizontal flourish extending to the right.

Jeffrey J. Cain, MD, FAAFP
Board Chair