October 27, 2010

Donald M. Berwick, MD, MPP
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Berwick:

The undersigned organizations urge the Centers for Medicare and Medicaid Services (CMS) to implement the Medicare Primary Care Incentive Payment (PCIP) program in a manner that does not exclude a significant number of primary care physicians. We are concerned that the CMS proposed implementation will preclude a significant number of primary care physicians who are providing comprehensive and longitudinal care from receiving the 2011 incentive payment, with primary care physicians in rural areas being most adversely affected.

Below are barriers that will prevent primary care physicians providing comprehensive and longitudinal care from qualifying for the incentive payment through the PCIP program as proposed by the agency.

- The proposal includes all Medicare Part B charges in the allowed charge denominator—out of which at least 60% of charges must be derived from designated primary care services. For example, physicians who maintain an in-office laboratory to provide timely testing would be less likely to qualify.
- The proposal penalizes primary care physicians who treat hospitalized patients. Following a patient in the hospital setting provides continuity of care and is a hallmark of traditional primary care practice. While the hospitalist movement has reduced the prevalence of primary care physician hospital visits, the number of primary care physicians making such visits remains significant. Approximately 61% of general internists report making hospital visits.[1] In survey of ACP members, 77% of general internists in active practice provide at least some inpatient care.[2] As beneficiaries in urban areas are more likely to receive care from a hospitalist,[3] rural primary care physicians are disproportionately harmed by criteria that associate hospital care as inconsistent with primary care.
- The proposal disadvantages rural primary care physicians who typically provide a broad range of services. A May 2009 paper by the American Academy of Family Physicians' Robert Graham Center titled, "Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges," which used incentive payment qualification criteria similar to those included in the Affordable Care Act, demonstrates this effect. In addition to providing inpatient and emergency

[1]ACP analysis of 2007 National Ambulatory Medical Care Survey data, using public data files accessed through http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS.
[2]ACP 2010 Member Profile. Philadelphia, PA.
[3] Kuo YF, Sharma G, Freeman JL, Goodwin JS. Growth in the Care of Older Patients by Hospitalists in the United States. New England Journal of Medicine. 2009 Mar 12; 360(11) 1102-12.

care, rural primary care physicians commonly furnish minor procedures such as aspiration, joint injections, and skin lesion removal. Also, the Graham Center, using data from the American Board of Family Medicine and the Dartmouth Atlas, has found a strong association between broader scope of practice in primary care and reduced Medicare costs.

Our organizations have individually submitted comments on the proposed rule to recommend several ways, alone or in combination, to mitigate the possibility that large numbers of of primary care physicians who provide comprehensive, longitudinal care to their patients will be ineligible for the PCIP. Actions that we recommend CMS consider taking in the final rule to prevent excluding worthy primary care physicians from the PCIP are:

- Establishing the denominator as charges derived only from Medicare Physician Fee Schedule professional services;
- Counting hospital evaluation and management (E/M) services as designated primary care services, which would include their associated allowed charges toward 60% minimum allowed charges threshold;
- Excluding hospital E/M service charges from the allowed charges denominator;
- Expanding the list of primary care services as it pertains to physicians in rural areas to include emergency department E/M services and select minor procedures, and
- Allowing rural primary care physicians whose Medicare allowed charges from inpatient and emergency services are under a certain threshold, e.g. 50%, to qualify for the PCIP.

In conclusion, our recommendations are consistent with those contained in the official comment letters submitted by our respective organizations prior to the August 24 public comment deadline. This letter—and the recommendations it contains—is not meant to substitute for each organization's previously-submitted recommendations, but to highlight that primary care and rural-oriented organizations are united in concern that the PCIP program will fail to meet its intended goal of boosting primary care physicians if CMS finalizes its proposed implementation, and to draw your attention to the range of options to mitigate the problem proposed by our respective organizations in our official comment letters. It also highlights that our organizations are united in the type of modifications that the agency needs to make in the final rule.

Sincerely,

American Academy of Family Physicians
American College of Physicians
American Osteopathic Physicians
National Rural Health Association

Copy:

Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services