Patient-Centered Primary Care COLLABORATIVE

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RE: Proposed Rule on Medicare Program, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011(RIN 0938–AP79)

The undersigned organizations are members of the Patient-Centered Primary Care Collaborative (PCPCC). PCPCC represents a diverse group of over 700 stakeholders on the front lines of health care delivery, including business, consumers, insurers, and clinicians. PCPCC has a number of principles including that primary care and the Patient-Centered Medical Home (PCMH) are the foundations of a high performing health care system.

The undersigned wanted to comment as a group regarding the notice of proposed rulemaking as it relates to the primary care incentive payment (PCIP). Section 5501(a) of the Patient Protection and Affordable Care Act (PPACA) provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B between January 1, 2011, and before January 1, 2016. Payments would be made on a quarterly basis. The law defined primary care services as those services identified by the following certain codes as of January 1, 2009.

CMS proposes to use 2009 data to identify primary care practitioners eligible for the Primary Care Incentive Payment (PCIP) based upon claims data and the practitioner's national provider identifier (NPI) number. This would include claims processed through June 30, 2010.

With respect to CMS's proposed implementation of the PCIP, we would observe the following:

1. *Quarterly payments.* We note that CMS proposes to use the discretion provided in the law to pay the PCIP on a quarterly (rather than on a monthly) basis. We support this approach. There are many different types of primary care practices that submit payments on different schedules. A quarterly distribution

will minimize the administrative requirements and fit more conveniently with most practice claims schedules.

2. *Definition of primary care services*. While the law defines primary care services for purposes of eligibility for and payment of the primary care bonus as a list of codes, we feel that the list is inadequate for capturing essential primary care services and that CMS has discretionary authority to adjust the list to reflect actual primary care services. We would note that the law includes discretionary authority when it defines primary care services as "services identified as of January 1, 2009, by the following HCPCS codes (*and as subsequently modified by the Secretary)*…" [Emphasis added]. The enclosed table provides the sets of codes that we would like to see added to the numerator used in qualifying primary care physicians for PCIP. See Attachment A.

3. *Identification of primary care practitioner.* To determine who is a primary care physician or provider, CMS proposes to use the primary specialty designation provided by the physician, nurse practitioner or physician assistant in billings submitted for services provided in the most current full year of claims data (i.e., 2009 for bonus payments to be distributed in 2011). CMS notes that the specialty designation is applied to each claim by the claims processing system. We support this initial identification process, since it administratively simple and non-burdensome.

However, we are concerned that, as CMS has noted, there will be opportunity for physicians or providers to change their specialty designation, and we support the subsequent proposal of CMS to monitor this switching process carefully. We agree that it will be appropriate to review the designation every year, based on the previous year's claims.

4. *Newly enrolled Medicare providers*. Since CMS is proposing to use a year of data to verify eligibility for the PCIP, newly enrolled Medicare providers will essentially have to wait a year before they could be eligible. We would suggest, as an alternative, that for newly enrolled primary care physicians and providers CMS consider using a six-month period of data. This could be a pre-defined six month period (e.g., January through June) or a six month period particular to the provider (e.g., his or her first six months of claims data). We note that CMS has six-month reporting periods as an option for determining PQRI payments, and it seems reasonable to offer that as an option for PCIP for newly enrolled primary care physicians and providers, too.

5. *No administrative or judicial review*. We agree with CMS that Congress has specifically emphasized the importance of distributing the PCIP in a timely way by eliminating administrative and judicial review of the agency's decisions. We

share the Congressional sense of urgency. We further agree with CMS's conclusion that this provision does not preclude CMS from correcting errors made from clerical or mathematical mistakes. We appreciate the willingness of CMS to accept information from physicians who believe the decision on their eligibility was based on such an error.

6. *PCIP payment regardless of other payments.* We agree that Congress has been clear that eligibility for the PCIP has no relation to any other payment that Congress has authorized. In other words, Congress has authorized a 10-percent bonus payment for physicians and providers who practice in Health Professionals Shortage Areas. Neither payment should affect eligibility for the other, since they are designed for different purposes.

7. *Medicare bonus payments for primary care.* Congress designed this eligibility threshold to ensure that the bonus payment was directed to primary care physicians and providers who were engaged in offering mostly primary care services. However, when calculating the percentage, CMS considers all Part B allowed charges, including lab and other ancillary services—including those that derive from physician orders even if they are not directly billed by the physician, to be in the denominator. We are concerned that including these non-office based services will greatly reduce the number of primary care physicians and providers who will be eligible for this bonus payment.

In a May 2009 White Paper, entitled "Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges," the Robert Graham Center estimates that only 59 percent of family physicians and general practitioners would be eligible. They further estimated that only 38 percent of internists, 23 percent of pediatricians and 63 percent of geriatricians would be eligible. Under contract to HRSA (Office of Rural Health Planning), the Graham Center has further demonstrated that there is a significant bias in the bonus payment calculation against rural primary care physicians, due to the fact that they must have a broader scope of practice to serve rural Medicare beneficiaries (unpublished). Rural physicians are more likely to deliver care in the emergency room, hospital, and to perform minor surgical procedures. As it stands, the threshold calculation may have the unintended consequence of narrowing scope of practice for rural physicians and of limiting access for rural Medicare beneficiaries. Under the same contract, the Graham Center has used data on scope of practice from the American Board of Family Medicine and from the Dartmouth Atlas and found a strong association between broader scope of practice in primary care and reduced Medicare costs. So, the bias against rural physicians and broad scope of practice in the bonus threshold calculations may ultimately work against Medicare's interest in lowering costs and securing access for beneficiaries. We

strongly believe that CMS should investigate ways within its authority to avoid these potentially harmful biases.

We thank you for this opportunity to comment on the proposed rule and look forward to working with you on improvements to the Medicare program.

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Signatures

Allen B Adolphe, MD
Allscripts Healthcare Solutions
American Academy of Family Physicians
American Association of Colleges of Pharmacy
American College of Clinical Pharmacy
American College of Physicians
Association of Departments of Family Medicine
California Academy of Family Physicians
Common Ground Integrative Health Inc.
Dow Chemical Company
Hooper Holmes
Institute for Behavioral Healthcare Improvement
Massachusetts Coalition for Primary Care Reform
Medical Network One
Minnesota Healthcare Network/Midwest IPA
Natl Found for Mental Health
PDA, Inc.
Practice of Joseph Mambu, MD
Practice Transformation
Primary Care Development Corporation
Robert Wood Johnson Medical School
SR Medical Center
University of South Alabama Deptartment of Family Medicine
WellPoint Inc.

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Appendix A

The following table provides the sets of codes that the members of PCPCC signing the attached letter would like to see added to the numerator used in qualifying primary care physicians for the 10% bonus enacted under PPACA.

Code Set	Value proposition
G0402 - Welcome to Medicare physical G0101 – Pelvic and breast exam Q0091 – Pap collection G0328QW – Fecal Occult Blood Test, immunoassay 82270QW – Fecal Occult Blood Test by peroxidase activity, screening G0103QW – Prostate Specific Antigen Test (PSA), screening 99406-07 – Smoking cessation counseling	CMS has encouraged physicians to help ensure that Medicare beneficiaries receive the preventive services they need.[1] The inclusion of these services that are commonly rendered by primary care physicians in the numerator for this bonus will help physicians further promote these valuable services and would not be expected to expand the bonus beyond primary care physician practices[2].
G0008 – Administration flu vaccine G9141- Influenza A (H1N1) administration 90655, 90656, 90657, 90658, 90660 – Influenza Virus Vaccine G0009 – Administration pneumonia vaccine 90669 – Pneumococcal Conjugate Vaccine 90732 – Pneumococcal Polysaccharide Vaccine G0010 – Administration hepatitis B vaccine 90740, 90743, 90744, 90746, 90747 – Hepatitis B Vaccine	CMS has noted that, "Despite Medicare coverage for influenza, pneumococcal, and hepatitis B vaccinations, the use of these benefits is not optimal."[3] The primary care physician practice is the ideal setting for patients to be advised about and receive these important preventive services. Inclusion of these services in the numerator for the bonus may facilitate expanded access to these services and would not be expected to expand the bonus beyond primary care physician practices.
G0179 - Re-certification for Medicare-covered home health G0180 - Certification for Medicare-covered home health G0181 - Supervision of home health services G0182 - Supervision of hospice services	Primary care provision of these care coordination services helps ensure that the plan of care for home health and hospice patients is up-to-date and that supplies and services ordered are appropriate to the patient's condition. Because these services are typically referred to the primary care

[1] https://www.cms.gov/MLNMattersArticles/downloads/SE0630.pdf, accessed 0/23/10

[2] Due to the scope of practice of most non-primary care specialists and higher allowable charges for procedural services, it is unlikely that the addition of the codes on this list would result in 60% of allowed charges.

[3] http://www1.cms.gov/AdultImmunizations/

G0372 - Documentation of need for power mobility device	physician, even after hospitalization overseen by other physicians, it would be appropriate to include these services in the numerator.
36415 – Venipuncture 85610 - Prothrombin time 81002 – Urinalysis, dip stick/tablet reagent, non-automated, w/o microscopy 81003QW - Urinalysis, dip stick/tablet reagent, automated, w/o microscopy 82947QW – Glucose, quantitative, blood 83036QW - Glycosylated hemoglobin test 83037QW - Glycosylated hemoglobin test, by home test kit	Certain laboratory services are common across primary care practices and the Medicare population. Provision of these services in the primary care practice provides for better care management (i.e., immediate action on physician recommendations vs. referral for action). Inclusion of these services in the numerator for the bonus may facilitate continued access and would not be expected to expand the bonus beyond primary care physician practices.
94010 – Spirometry 94060 – Spirometry, pre- and post-bronchodilator admin.	Spirometry, in addition to clinical examination, improves COPD diagnostic accuracy compared to clinical examination alone and it is a useful diagnostic tool in individuals with symptoms suggestive of possible COPD. The primary benefit of spirometry is to identify individuals who might benefit from pharmacologic treatment in order to improve exacerbations. These include adults with symptomatic, severe to very severe airflow obstruction.[4] AAFP survey data indicates spirometry is provided by 65% of family physician members making addition of this service to the numerator supportive of continued quality care. While this service is also offered by physician other than primary care physicians, it is unlikely that the addition of these codes would expand the bonus beyond primary care.

[4] http://www.ahrq.gov/clinic/tp/spirotp.htm