addition, AHRQ's Improving Primary Care Initiative currently sponsors a number of initiatives related to improving care for patients with MCC, including work on: care coordination, team-based care, self-management support, clinical decision support, integration of behavioral/mental health with primary care, clinical-community linkages, health information technology integration, and healthcare/system redesign.

The AHRQ MCC Research Network comprises 18 pioneer grant projects funded in 2008, and an additional 27 grant studies funded in 2010 through the American Recovery and Reinvestment Act (ARRA). Each of the 2008-funded studies focused on the use of preventive services for patients with MCC to improve understanding about which interventions provide the greatest benefit to people with MCC. The 2010 funded grants focused on exploratory research or infrastructure development to address comparative effectiveness research to optimize prevention and healthcare management for the complex patient. Roughly one-half of the 2010 funded grants used existing, or easily developed, data sources to help prioritize testing and treatments for patients with MCC, and to suggest appropriate adaptations to recommended care guidelines. The remaining investigators developed new datasets or other infrastructure to fill a void in research on MCC and conducted pilot studies to demonstrate the use of the new infrastructure. They also worked to make these new data sets publically accessible to other researchers. AHRQ also funded a Technical Assistance Center (TAC) to support the work of the MCC Research Network by facilitating information sharing and collaboration across the Network investigators. The TAC is staffed by Abt Associates, the MacColl Center for Healthcare Innovation, and the Inter-University Consortium for Political and Social Research (ICPSR).

Where to Get More Information

MCC Research Network Results and Products

Findings and other materials developed through the AHRQ MCC Research Network are being disseminated through various mechanisms, including the AHRQ MCC Research Network website: http://www.ahrq.gov/research/mccrn.htm.

Access to MCC Research Network Data Several of the datasets developed as a part of this work are publicly available, and are housed on the AHRQ MCC Research Network Data Archive site: http://www.icpsr.umich.edu/icpsrweb/AHRQMCC/.

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AAFP From the American Academy of Family Physicians

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CMS PROPOSES NEW CODES IN 2014 FEE SCHEDULE TO BENEFIT FAMILY PHYSICIANS

The AAFP's significant work to urge the Centers for Medicare and Medicaid Services (CMS) to recognize the work involved when family physicians and other primary care professionals take care of patients with chronic conditions is bearing fruit. For example, in the proposed 2014 Medicare physician fee schedule (MPFS), CMS is recommending new codes in 2015 to manage complex chronic care (CCC) conditions, a mainstay of most primary care physicians' practices.

CMS said it is "proposing to establish a separate payment under the MPFS for complex chronic care management services furnished 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."

A recent AAFP summary of the proposed MPFS, available at http://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/ES-2014ProposedFeeSchedule-071913.pdf notes that these new codes represent a step toward a more equitable payment system that would better recognize and reward the provision of primary care physician services.

CMS is proposing 2 new G-codes: one for the initial service and another for subsequent care after the initial service. The agency would pay only 1 G-code per patient during a 90-day period. CMS has not yet determined the payment amount, but, according to the

AAFP summary, the agency did indicate that the code would cover at least 60 minutes of clinical time.

"Patients will be required to provide advance consent to the practice for the CCC management codes to be used, and this consent must be reaffirmed every 12 months," the summary says. Patients also must receive an annual wellness visit or initial preventive physician exam within the previous 12 months before a physician can bill for the CCC management code.

The proposal of the CCC management codes follows enactment of post-discharge, transitional care management (TCM) codes that CMS established for 2013. The TCM codes pay primary care physicians and other primary care health professionals for furnishing a range of care-coordination services after a patient is discharged from a hospital or other health care facility.

In a December letter to CMS and another letter in March, the AAFP and other organizations praised CMS for the TCM codes and urged the agency to initiate Medicare coverage of CCC management services.

The AAFP summary of the MPFS also looks at changes in the Medicare conversion factor for 2014. Two tables in the summary outline payment updates by percentage for a number of specialties, including family physicians. According to CMS estimates, family physicians will see a 1% increase in their Medicare allowed charges based on the proposed rule. The increase for family physicians, although small, is above the average. Many subspecialties received a negative update, including dermatology (-2%), neurology (-2%), otolaryngology (-2%) and radiation oncology (-5%).

However, the proposed MPFS also reflects a pending 24.4% cut in the Medicare payment rate that is scheduled to take effect on Jan. 1 as a result of the sustainable growth rate (SGR) formula. In the summary, the AAFP again calls on Congress to repeal the SGR because those pending cuts undermine CMS' efforts to implement real payment reform.

Other items covered in the AAFP summary include:

- equalizing certain payments for procedures done in physician office settings with payments for the same procedures done in a hospital outpatient setting or an ambulatory surgery center
- information on the 2014 geographic practice cost indices (GPCI), as the work GPCI floor of 1.0 is set to expire at the end of December unless Congress intervenes
- the addition of the new TCM codes to the list of telehealth services for 2014
- changes to the Physician Quality Reporting System
- new options for reporting clinical quality measures for the Medicare Electronic Health Record Incentive Program
- a proposal to set 2015 as the performance period for the value-based payment modifier applied during 2017 (the previous period established 2013 as the performance period for 2016)
- a proposal to lower the threshold for health care professionals subject to the value-based payment modifier in 2015 to groups of physicians with 10 or more eligible professionals.

The AAFP is working on a letter that responds to the proposed fee schedule. Deadline for submission of comments on the proposed schedule is September 6, 2013.

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