AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

June 8, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW.,
Washington, DC 20201

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the proposed rule regarding the 2018 Hospital Inpatient Prospective Payment (CMS–1677–P) as published by the Centers for Medicare & Medicaid Services (CMS) in the April 28, 2017 *Federal Register*.

The AAFP is the only medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits. This represents more than 192 million visits annually, which is 48 percent greater than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Our members are at the frontline of care delivery and are the trusted partners that millions of people rely upon for health and wellbeing.

We offer the following comments to sections of this proposed rule that impact family physicians and other primary care physicians.

Medicaid Electronic Health Record (EHR) Incentive Programs
The AAFP applauds CMS for aligning the reporting period for Medicaid EHR Incentive Program eligible professionals (EPs) who choose to report electronically with the reporting period for Merit-based Incentive Payment System (MIPS) reporting, to now also be any 90 continuous days during the 2017 performance year.

We have concerns regarding a full year reporting requirement for Medicaid EPs who choose to report via attestation. MIPS quality reporting options do not include an option to report via attestation, and because the reason for proposing a shortened 90-day reporting period for Medicaid EPs who report electronically was to align all *electronic* reporting periods, CMS believes there is not a valid application of this proposed brief period for those EPs who report via attestation. However, it is important to recognize there will be confusion among Medicaid EPs that the new 90-day reporting period is only applicable to those EPs who report electronically. In

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addition, busy practicing physicians may not be aware of the requirement, and may mistakenly perceive the 90-day reporting period as applicable to all Medicaid EPs.

There are also challenges with requiring a full year reporting period for Medicaid EPs who report via attestation. Members report that as they prepare to acquire 2015 Edition certified EHR technology (CEHRT), which is a disruptive process to the clinical workflow, they are also considering whether now would also be the ideal time to switch EHR vendors due to lack of functionality that meets their needs. It should be noted that this will occur at a point when upgrading to 2015 Edition CEHRT could minimize the number of significant disruptions to patient care. As some members have begun the process of switching EHR systems, reports of information blocking occurring by the prior CEHRT vendor have proliferated. Due to this increased information blocking, we have concerns regarding a full year reporting requirement.

Outside of this, **we are supportive of the alignment of electronic reporting periods to any 90 continuous days; though recommend the reporting period for CQMs be the same for any CQM reporting method.**

Regarding CMS' proposal for 2017 Medicaid EPs to be required to report on any six measures that are relevant to the EP's scope of practice, the AAFP is supportive of harmonization of CQMs and the reporting requirements across all programs of CMS and across all payers. We strongly recommend the core clinical measures collaborative measures be used for this purpose.

The AAFP strongly agrees with the assumption that there will be substantial numbers of EPs that will not be ready to use a 2015 Edition CEHRT beginning on January 1, 2018. We agree with the proposed 90-day reporting for Medicaid EPs for 2018.

It is unclear how CMS will address a decertification before a reporting period ends. CMS must provide further guidance on options for EPs under Meaningful Use, and ECs under the Advancing Care Information (ACI) component of MIPS, whose EHR becomes decertified.

The AAFP does not share CMS' optimism about the level of 2015 Edition CEHRT deployment for the 2018 reporting period, even with the flexibility created by the proposed 90-day reporting period. As the meaningful use program is littered with instances of last minute changes to meet the reality of slower than projected progress, the AAFP urges CMS to allow use of 2014 Edition CEHRT in 2018. CMS should give EPs flexibility in adoption of 2015 Edition CEHRT while still incenting their adoption. **To do this we recommend that the 2017 Transition year base ACI criteria be continued in 2018 (the 2018 performance criteria would remain the same) – and allow EPs to use 2014, 2015, or combination CEHRT.** This flexibility will allow EPs that will struggle in adopting 2015 Edition CEHRT in 2018 the option to use the 2014 Edition. It will also incentivize 2015 Edition CEHRT by providing a higher possible point total: the total possible points of using a 2015 Edition CEHRT or combination would be 155 where as a 2014 Edition CEHRT would only allow for a total score of 135.

V.I.11. Accounting for Social Risk Factors in the Hospital Readmissions Reduction Program
In this proposed rule, CMS seeks public comment on whether the agency should account for social risk factors in the Hospital Readmissions Reduction Program and, if so, what method or combination of methods would be most appropriate for accounting for social risk factors.

It is the mission of the Academy to improve the health of patients, families, and communities by serving the needs of members. The AAFP recently established a Center for Diversity & Health Equity to advance diversity and health equity in primary care. The Center for Diversity & Health Equity's activities will include evaluating current research on the social determinants of health and health equity with a strong focus on collaboration, advocacy and policy. In their patient-centered practices, family physicians identify and address social determinants of health for individuals and families, incorporating this information in the biopsychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care.

Regarding the proposed rule's request for methods appropriate for accounting for social risk factors, the AAFP concurs with the recommendations provided by Weissman, et. al., that pay for performance designs should consider concurrently both quality and disparities using a two-stage reimbursement strategy. While we understand there are challenges to operationalizing this approach, we believe work is needed to move in this direction in a stepwise fashion. We agree with the paper's findings, that a combined ranking method is a potential solution to mitigate unintended consequences of pay for performance programs, while helping to reduce national disparities within a framework that still focuses on improving quality.

The proposed rule also requests feedback on which social risk factors might be most appropriate for stratifying measure scores and or potential risk adjustment of a particular measure. The AAFP supports the development of a strategy to operationalize the integration of intersectionality theory into its design method to account for social risk. For more information on this concept, we recommend two related articles, Intersectionality in Primary Care and Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. The use of a single social determinant (race, gender, or geography) is unable to comprehensively consider the unique interactions between social determinants of health. Again we recommend that CMS begin a stepwise strategy where, eventually, multiple social determinants of health will be integrated into health care processes and payment methodologies. But we strongly urge CMS to start with small steps to create traction in the market and to further the evidence base to inform the integration of social determinants of health into payment models. We believe a first step could be to leverage the existing demographic data in Certified EHR Technology and add poverty and educational level. For further methods to separately risk adjust for population health, we urge CMS to consider the "Advanced Primary Care: A Foundational Alternative Payment Model (APM)" proposal that is currently under review by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

XIII.C. Request for Information on CMS Flexibilities and Efficiencies

The AAFP greatly appreciates that CMS is committed to transforming the health care delivery system by putting an additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes while reducing burdens for hospitals, physicians, and patients.

As articulated in greater detail in an April 26, 2017 letter to CMS and prompted by the Executive Order on Reducing Regulation and Controlling Regulatory Costs, which the AAFP strongly supports, the AAFP provided recommendations regarding ways to meaningfully improve and simplify implementation of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

We intend these recommendations to better enable independent primary care practices to serve their patients and communities. Unfortunately, family physicians are facing a regulatory environment that is pulling them from caring for their patients. A recent study found that physicians reported spending nearly 50 percent of their in-office time on administrative and EHR-related work – and only 27 percent on direct patient care. Family physicians face a regulatory burden that is unmatched among the various medical disciplines. This burden ranges from onerous documentation guidelines to cumbersome prior authorization criteria and the ongoing frustrations associated with electronic medical records. In addition, we urge CMS to review a document titled "Prior Authorization and Utilization Management Reform Principles" that the AAFP and a coalition of 16 other organizations published.

The AAFP believes that Congress intended MACRA to simplify Medicare payment, quality improvement, and performance measurement programs. We also believe that if the Executive Order had been in place when CMS released the initial MACRA proposed rule, the rule would have better met Congressional intent instead of introducing new complexities that do not improve care for beneficiaries. In particular, we fully agree with MedPAC that MIPS is an overbuilt system that will not succeed.

We believe there are still a number of areas where CMS can simplify the design of the Quality Payment Program (QPP) and its administrative requirements. Thus, much more work remains to keep reporting and regulatory burdens to a minimum, which we understand is a shared goal of the Administration.

In summary and regarding MACRA implementation, the AAFP strongly encourages CMS to:

1. Remove financial risk from regulatory definitions of the Medical Home Model.
2. Remove arbitrary size restrictions limiting AAPM participation in Medical Home Models.
3. Eliminate all documentation guidelines for evaluation and management codes for primary care physicians in both the MIPS and AAPM pathways.
4. Jettison the complicated and entirely uncalled-for MIPS APM category.
5. Eliminate administrative claims population health measures.
6. Use consistent terms from proposed to final rulemaking to avoid confusion in the physician community.

In addition to eliminating the above provisions, the AAFP urges CMS to modify the following requirements in order to improve and simplify MACRA for CMS and physicians:

1. Primary Care Payment Recommendations:
    a. Immediately adjust upward the Medicare relative value units (RVUs) for common primary care services in order to pay appropriately for those services which as a family of CPT codes and services are greatly undervalued compared to other groups of CPT codes and services.
    b. Increase spending on services provided by primary care physicians in the Medicare Part B program to, at minimum, 15 percent of Medicare Part B physician spending. This increase should be achieved over time through increases in the primary care workforce, the percentage of office-based visits that are conducted by primary care physicians, the aforementioned increase in the RVUs for primary care services, and through further investment in and payment for primary care AAPMs.
    c. Consistently define the size of a “small” practice as 10 or fewer eligible clinicians.
2. Advanced Alternative Payment Model Recommendations:

   a. Support patient-centered primary care models that both strengthen primary care and allow small practice participation as new AAPMs are developed.
   b. Do not replace fragmented fee-for-service (FFS) with fragmented condition or specialty-specific APMs.
   c. Consider and release new AAPMs in a timely fashion, so practices can participate.
   d. Make primary care-oriented AAPMs available nationally to all primary care physicians.
   e. Review and implement the AAFP's "Advanced Primary Care: A Foundational Alternative Payment Model (APM)" proposal made to PTAC.
3. Establish a more gradual MIPS transition period, promote successful participation, and provide actionable and prompt (i.e. at least quarterly) feedback to help physicians progress into AAPMs.
4. Virtual Groups Recommendations:
   a. Offer an interim pathway in 2018 to virtual groups such that physician practices with 10 or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of certified electronic health record technology (CEHRT), and involvement in improvement activities should be exempt from any negative payment adjustments until virtual groups–as outlined and mandated by MACRA–are readily established.
   b. Redirect such funds as necessary from the $500 million intended for positive payment adjustments to "exceptional performers" to finance this proposed safe harbor for solo and small group practices.
   c. Prioritize establishing virtual groups as envisioned in the law.
5. ACI Recommendations:
   a. Move away from health IT utilization measures and simplify QPP and ACI.
   b. Evaluate ACI's impact on physician experience and implement changes that reduce unnecessary burden.
   c. Allow ECs to use 2014, 2015, or combination CEHRT, if the ACI scoring and methodology is not fundamentally changed and continue the 2017 transition year base ACI criteria in 2018 while moving forward with the planned 2018 performance measuring and scoring.
   d. Maintain a 90-day reporting period.
6. Quality Measure Recommendations:
   a. Use only the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.
   b. Require all physicians participating in the MIPS program to meet the same program expectations and report on the same number of measures.
   c. Release MACRA measure development funding.
7. Continuing Medical Education (CME) as Improvement Activities.
   a. Approve for fulfillment of improvement activities any CME activities that are designed to measurably improve performance and/or patient outcomes.
   b. Utilize AAFP's reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities.
   c. Include PerformanceNavigator® live course and PerformanceNavigator® On Demand (online) among CMS's approved improvement activities.
8. Coding Recommendations:

   a. Provide additional information on how patient-relationship categories and codes will be used to attribute cost and patient outcomes to physicians.
   b. Thoroughly pilot test these patient-relationship categories and codes before their use impacts payments.
   c. Minimize the reporting burden for physicians through pilot testing to address logistical issues, especially for small practices.
9. Simplify and stabilize the Improvement Activities scoring process by only requiring practices to do three activities, each carrying a weight of 5 percentage points, to obtain the 15 percent needed in the category.
10. Reduce the acceleration of data completeness criteria standards.
11. Make AAPM incentive payments to QPs (i.e. "to such professional") as identified by either the QP's National Provider Identifier (NPI) or TIN/NPI combination.

The implementation of MACRA will impact our health care system for years to come, and it must be done thoughtfully, carefully, and as simply as possible. The AAFP sees a strong and definite need for CMS to step back and reconsider the current approaches to MACRA, which we view as overly complex and burdensome to physicians. Given the significant complexity of these programs, we strongly encourage CMS to follow the AAFP's recommendations by which CMS can better align the requirements with the goals and intent of the legislation. The AAFP and our members stand ready to assist CMS in ensuring that the MACRA regulations achieve the goals established by the law, and advance high-quality and efficient health care for Medicare beneficiaries. We welcome the opportunity to further discuss our ideas and policy proposals.

Separate from MACRA implementation but regarding reducing burden in the Medicare program, the AAFP provides the following recommendations and encourages CMS to reduce the administrative burden in these areas:

- Prior Authorizations: The frequent phone calls, faxes, and forms physicians and their staffs must manage to obtain prior authorization for an item or service create enormous burden. A large part of that burden stems from these unfunded prior authorizations (PA) requirements. PAs are becoming increasingly common as employers and insurance companies struggle to control escalating pharmaceutical, radiological, and medical equipment costs. Since a majority of family physician practices have contractual relationships with seven or more payers, they must often navigate seven or more different prior authorization rules and forms. The AAFP asks CMS and Congress to eliminate the use of PAs in the Medicare program for generic drugs, create a single PA form that all Medicare Part D plans must use, and further limit or reduce the number of products and services requiring PAs. The AAFP suggests that CMS require Medicare Advantage (Part C) and Part D plans to pay physicians for PAs that exceed a specified number or that are not resolved within a set period of time; prohibit recurrent PA requirements for ongoing use of a drug by patients with chronic disease; prohibit PAs for standard and inexpensive drugs; and require that all plans (public and private) use a standard PA form and process.
- Evaluation and Management Services: The current CMS Documentation Guidelines for Evaluation and Management (E/M) Services were written 20 years ago and do not reflect the current use and further potential of electronic health records (EHRs) and team based care to support clinical decision-making and patient centeredness. These documentation guidelines have resulted in 'clunky' EHRs that have only been designed to document 'bullets for billing' in a fee-for-service payment system rather than the needed focus on patient and population health. The AAFP believes there should be changes in these

outdated documentation guidelines as well as the Medicare Program Integrity Manual to make it clear that any documentation entered into the medical record by the team related to a patient's visit would be considered in determining and supporting the submitted code. Most importantly, we strongly recommend that all documentation guidelines for E/M codes 99211-99215 and 99201-99205 be eliminated for primary care physicians.

- Translation Service Costs: Since 2000, physicians have been required to provide translators for Medicare and Medicaid patients with hearing impairments or limited English proficiency, and on October 17, 2016, new and costly limited English proficiency policies went into effect. Family physicians already operate on slim financial margins. The AAFP strongly believes that Congress and HHS must procure the necessary funding to address and offset the estimated financial burden on physician practices. We have significant concerns that primary care practices are already taking a financial loss for treating patients that require interpretive services because of the historical undervaluation of primary care services in the resource-based relative value scale system. Medicare and Medicaid payment for essential primary care services are simply inadequate and interpretive services remain costly. If the patient reschedules or does not appear for the appointment, the practice must still pay the interpreter. We believe that HHS must fund the increased costs practices will bear to comply with these requirements. If this cannot be accomplished, we call on HHS to eliminate this requirement.
- Quality Measure Harmonization and Alignment: The AAFP believes more work must be done in quality and performance measure harmonization. This harmonization should focus on aligning measures across all public and private payers, including Medicaid. Physicians, especially family physicians, bear the brunt of quality and performance measures. A major part of this is the burden of multiple performance measures in quality improvement programs with no standardization or harmonization. The AAFP urges CMS to align quality measures as part of their overall approach to reducing administrative burden. To accomplish this, the AAFP recommends that CMS, in all federal programs and demonstrations, use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures among all payers.
- Electronic Health Record (EHR) Interoperability: Family medicine has been a leader in practice transformation, delivery system reform, and EHR adoption. However, to truly achieve improved quality and reduce the cost of care, it is critical to have appropriate technology and data infrastructure to support more efficient and effective health care delivery. Based on data from surveys the AAFP and others have conducted, the current health IT infrastructure and products are neither efficient nor effective in supporting practice transformation. Therefore, all physicians need the national health IT ecosystem to undergo more rapid transformation than has been the case to date. We need systems that provide interoperability to support continuity of care, care coordination, and the ability to switch and integrate different health IT solutions (such as EHRs) with minimal disruptions. Physicians also need population management and patient engagement functionalities that require broad interoperability. These new features, as well as the old, need to be developed with user-centered design and take into account the transformed practice environment. Furthermore, we call on HHS to place the burden of compliance on EHR vendors and not on physicians. EHR vendors must be held accountable for the inadequate design and poor performance of their products, not the physicians who struggle to use these products in their practices.

- Chronic Care Management Documentation: The 2017 Medicare Physician Fee Schedule Final Rule made great strides to simplify the requirements of Chronic Care Management (CCM) regarding consent and access to the care plan. The AAFP believes that the documentation requirements are still excessive and should be further reduced. We also support the elimination of the cost-sharing requirements associated with the service.
- Appropriate Use Criteria (AUC) Alignment with MIPS: The AAFP has ongoing, significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements. Much like prior authorization requirements noted above, we believe that AUC requirements will place more burdens on primary care physicians than on other clinicians and add an unnecessary level of complexity to the already complex Medicare system that severely overtaxes our members. **The AAFP, therefore, strongly urges CMS to at least delay the implementation of this program, so AUC would be aligned with the forthcoming MIPS program in 2019, versus being introduced as a stand-alone program – in fact, we would prefer that this program and regulatory burden be discontinued completely.** With the passage and implementation of MACRA, which begins to align payment with value, the need for AUC requirements has been supplanted, and those requirements will now likely hinder, rather than improve, effective care.
- Inconsistent Claims Review: There are a multitude of post-claims review processes: ZPIC, RAC, CERT, Meaningful Use, etc. Within these audit programs, there are a multitude of requirements, appeals processes (if any), differing deadlines, and governing agencies. Communications from these entities are not easily understood by busy physicians nor are their deadlines easy to meet. Monitoring activity is recognized as necessary, however the AAFP strongly recommends that CMS streamline programs and utilize one set of criteria that is universal.
- Transitional Care Management Services: Communication and EHR interoperability barriers continue to hinder the uptake of transitional care management (TCM) services. The stringent and brief time frames for patient contact after hospital discharge in addition to the lack of open communication between hospitals and primary care physicians impedes family physicians' ability to provide these important services and bill these codes. Enhanced EHR and HIE (health information exchange) would reduce the burden on both physicians and hospitals and provide for reduced patient readmissions. These activities would in turn result in reduced cost for physicians, hospitals, health plans, and government payers.

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair