AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 11, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Re: Primary care policy recommendations to support successful MACRA implementation

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write to articulate our vision of how the *Medicare Access and CHIP Reauthorization Act* of 2015 (MACRA) can fundamentally change our health care delivery system to achieve the goals of improving the patient experience of care, improving the health of populations, and reducing the cost of health care.

The AAFP believes that MACRA is, by intent and design, a law aimed at transforming our health care delivery system into one that is based on a strong foundation of primary care. A review of the law clearly demonstrates that Congress wanted a greater priority placed on comprehensive, continuous, coordinated, first contact, and connected primary care. The emphasis placed on these priorities and the significant attention paid to the patient-centered medical home (PCMH), in particular, are direct articulations of Congress' desire to see our health care delivery system more aggressively promote, reward, and emphasize primary care as the foundation of our health care system.

We recognize that a robust and well-financed health care system built on primary care is a goal that CMS also strongly supports, and we look forward to working closely with you to ensure that MACRA facilitates the achievement of that goal. This letter outlines a series of recommendations that would facilitate this shared vision to implement MACRA in a manner that fully optimizes delivery and payment reforms that emphasize the value of comprehensive, continuous, coordinated, first contact, and connected primary care to both patients and payers.

Value of Primary Care Services in the Medicare Physician Fee Schedule

Given the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) will evolve from the existing fee-for-service payment system, addressing flaws in current payment rates and methodologies will be critical to successful transition to, and implementation of, MACRA. Primary care is particularly affected by longstanding inequities in payment that must

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be corrected if primary care is to be the foundation of new payment and delivery models. Payment experts offer similar assessments of the problems with testing and building value-based payment models on a flawed physician fee schedule. Dr. Robert Berenson and Dr. John Goodson recently wrote in the *New England Journal of Medicine, "*If the foundation of Medicare's fee schedule isn't sound, these systems will be unstable." According to the 2016 Medicare Payment Advisory Commission (MedPAC) report, compensation continues to be much lower for primary care physicians than for physicians in subspecialty disciplines.

The AAFP fully agrees with the article and report. These drastic payment discrepancies continue to raise serious concerns about fee schedule mispricing and its resulting negative impact on primary care. To help ensure the success of MIPS and APMs, the AAFP offers several recommendations to address these issues, as well as key findings and research to support our recommendations.

Appropriate Valuation of Relative Value Units
Despite our support for MACRA and optimism regarding the APM pathway, the AAFP is apprehensive that the MIPS and APM programs will fail if they are built upon the biased and inaccurate relative value data currently used in fee-for-service payments. CMS currently undervalues evaluation and management (E/M) codes and other primary care services. Without remedying this flaw, payments under MIPS and future actuarial calculations for APMs will not adequately compensate primary care for the complexity of care provided – and could undermine broader goals to improve care, improve health, and reduce costs. **Therefore, the AAFP strongly recommends that Medicare immediately adjust upward the relative value units (RVUs) for common primary care services in order to pay appropriately for those services now and in these new payment programs and models.** Currently, services provided by primary care physicians represent between four to six percent of Medicare Part B physician spending. The AAFP urges CMS to use its authority to increase such spending on services provided by primary care physicians in the Medicare Part B program to, at minimum, 15 percent. 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, and the aforementioned increase in the RVUs for primary care services. We strongly believe that payments should accurately reflect the current and future role primary care will play in meeting the wide range of needs of Medicare beneficiaries.

As the agency considers primary care payment policies, we advise CMS to consult closely with the Primary Care and the Triple Aim annotated bibliography, which demonstrates the capacity of primary care to improve America's health care system. It first articulates the value and history of primary care to characterize the importance of primary care's core tenets, which are first contact, continuity, comprehensiveness, coordination, and community orientation. It then explores the current primary care landscape and presents key emerging trends and themes, such as the problems in the primary care workforce and the shortage and poor geographic distribution of primary care physicians. Finally, this work presents evidence that clearly demonstrates the positive impact primary care has on improving patients' experience of care, reducing costs, and improving population health.

Reexamine Structure and Documentation Guidelines of E/M Services
CMS should also explore the structure and documentation guidelines of E/M services to better distinguish primary care services from the E/M services provided by non-primary care physicians.

The AAFP encourages CMS to consider Dr. David Katerndahl's work "Complexity of ambulatory care across disciplines," which notes, "The work relative value unit (RVU) assigned to ambulatory visits is identical across specialties with the assumption that the work is equivalent for each specialty. This assumption is faulty." His research suggests that E/M services do differ significantly among specialties, with surgical specialties being on the low end of the complexity-density scale. Current E/M coding and documentation guidelines do not recognize this distinction. Dr. Katerndahl's research demonstrates that the current outpatient E/M codes mask a wide spectrum of services, which often vary by physician specialty. **The AAFP urges CMS to incorporate this research in its efforts to correctly assess the value of global surgical services and to appropriately value the complexity of primary care services.**

In addition to reassessing the current structure of E/M coding values, CMS needs to revise its documentation guidelines for E/M services. The current guidelines were written almost 20 years ago and do not reflect the current use and further potential of electronic health records (EHRs) to support clinical decision-making and patient-centeredness. The documentation guidelines that accompany the current code descriptions were initially felt to be necessary because of significant ambiguity in code selection. However, they have proven to be counterproductive for a number of reasons, including the negative impact on the integrity of the clinical record and on accurate coding. **We request that CMS conduct a study of the impact of the E/M documentation guidelines on both clinical care and program integrity with an added focus on whether the current coding structure should be revised to support implementation of MACRA.**

Furthermore, the E/M documentation guidelines do not support team-based care, which will be necessary to succeed under MIPS and APMs. In current medical practice, information is gathered and generated by ancillary staff members, care coordinators, and sometimes by kiosks whose information becomes part of the medical record. Yet, Medicare contractors and others interpret the documentation guidelines to mean that the physician or other qualified health care professional under whose name the service is billed must document all parts of the E/M service except for vital signs, review of systems, and past, family, and social history. This interpretation is reinforced and compounded by section 3.3.2.1.1(B) of chapter three of the *Medicare Program Integrity Manual*. **We believe that all the elements of team-based care that are part of the patient office visit, if reviewed and finalized by a physician or other qualified health care professional, should be considered part of the E/M service and should be considered supporting documentation for the coding that follows the information entered.** Accordingly, we advocate that CMS revise its Documentation Guidelines for E/M Services and *Medicare Program Integrity Manual*.

Measuring Complexity of E/M Services
Additional information CMS should consider when valuing primary care services is found in a recent snapshot survey of AAFP physicians:

- Seven in 10 respondents have experienced an increase in the number of health issues addressed in a single office visit.
- More than half said more patients sought treatment for conditions they had previously ignored.
- Sixty-two percent noted an increase in patients seeking an annual check-up.
- More than four in 10 said they witnessed an increase in patients with severe health complications.

These findings echo similar findings from the study, "Complexity of ambulatory care visits of patients with diabetes as reflected by diagnoses per visit," published in the February 2016 issue of *Primary Care Diabetes*. It reported:

- Almost 70 percent of visits in which only one diagnosis was reported were to subspecialist physicians. Almost 90 percent of visits in which four diagnoses were reported were to primary care physicians.
- While 55 percent of visits to primary care involved care for at least one additional diagnosis; 20 percent of visits made by adults with diabetes to subspecialists involved care for at least one additional diagnosis.

Furthermore, according to the 2006-2008 National Ambulatory Medical Care Survey data analyzed by the Altarum Institute, family physicians often treat a larger percentage of the visits for complex conditions (e.g., circulatory, endocrine, and respiratory disorders) than many sub-specialists.

Additionally, more comprehensive care among family physicians is associated with lower costs and fewer hospitalizations, according to an article published in the *Annals of Family Medicine*. The AAFP, therefore, calls on CMS to implement payment and other policies that support and encourage primary care comprehensiveness.

Definition of the Patient Centered Medical Home

The AAFP strongly supported the inclusion of the Patient-Centered Medical Home (PCMH) in MACRA. We continue to believe this advanced primary care delivery model, when aligned with an appropriate payment model, represents the best path for empowering primary care to achieve the goals of improving the patient experience of care, improving the health of populations, and reducing the cost of health care. We will state explicitly that we do not consider the PCMH tantamount to third-party recognition as a PCMH. The PCMH is a set of functions within a practice, not something granted by a third party. The AAFP encourages CMS to consider the Joint Principles of the Patient-Centered Medical Home and the key functions of the Comprehensive Primary Care (CPC) initiative as criteria for determining what constitutes a PCMH. The Joint Principles, when aligned with the five key functions of the CPC initiative, capture the true definition of a PCMH and its performance thresholds. Furthermore, we do not believe a physician should be required to pay a third party to secure the recognition necessary to participate in a Medicare program.

Establishment of the Performance Year(s)

The AAFP understands that CMS must maintain an accelerated pace to develop MACRA implementing regulations and that physicians will have little time to prepare to participate in either the APM or MIPS pathways. However, true and meaningful primary care transformation is a complex and a long-term endeavor. Research has shown that the transformation process can take 18 months to three or more years, depending on the starting point and resources available to the practice. That is why we urge CMS to provide flexibility in establishing the performance and payment years. Specifically, the AAFP calls on CMS to consider using 2018 as the initial assessment period for MACRA. If this is not possible, we call on CMS to use, at the very least, the second half of 2017 (July 1, 2017 – December 31, 2017) as the initial assessment period for physicians, whether they are participating via the MIPS or APM pathways. CMS has in recent years shortened the evaluation time to allow for greater preparation and participation by physicians. We strongly urge CMS to exercise that authority once again with respect to the implementation of MACRA.

In addition, for APMs and MIPS to be successful, CMS must provide actionable feedback in near-real-time to primary care physicians for them to make informed decisions. Current CMS payment systems rely on a two-year lag between the performance year (when data is collected and reported) and the payment year. **The AAFP continues to believe that two-year old data is not clinically actionable or meaningful, and we implore CMS to explore ways to realistically provide actionable feedback within one year or less.**

Primary Care Alternative Payment Models

The AAFP views the APM pathway as the best opportunity for family physicians, because it promotes new delivery and payment approaches that move away from a fee-for-service system. The APM pathway also promotes and finances comprehensive, continuous, coordinated, first contact and connected primary care. Accordingly, we strongly support moving a larger percentage of payments for primary care physicians from the traditional fee-for-service model toward APMs, and we are urging our members to prepare their practices rapidly for the APM pathway. However, in order for primary care physicians to participate in this pathway, APM options must be available.

The AAFP continues to support the multi-payer Comprehensive Primary Care (CPC) initiative that tests and evaluates practice transformation models by paying selected primary care practices a care management fee, in addition to fee-for-service, to support enhanced, coordinated services for Medicare beneficiaries and other patients**. Since CPC results have been favorable in terms of improved quality, the AAFP urges CMS to expand the CPC initiative nationally. In addition to expanding the CPC initiative as a Center for Medicare & Medicaid Innovation (CMMI) model, the AAFP calls on CMS to recognize the CPC initiative as a qualifying APM.**

Last, the AAFP would like to emphasize that MACRA exempts advanced primary care practices from meeting nominal risk criteria to meet APM pathways. This will provide an opportunity for more primary care physicians to participate in APMs, allowing more Medicare patients to benefit from access to advanced primary care.

Meaningful Use

The AAFP remains pleased that CMS continues to reexamine and improve the Meaningful Use (MU) program. We share your perspective that, while the MU program may have “met its goals and served its usefulness,” it should be "replaced with something better." We stand by our previous recommendation that CMS implement a shortened reporting period in 2016 to help enable physicians’ transfer to the MIPS and APM programs. As an initial step to facilitate increased physician success, **we request CMS adopt the same 90-day reporting period policy for participants in the MU program that was offered in 2015. We also specifically recommend CMS allow participants to report on any 90-day period in 2016, as was the policy in 2015 and in each prior program year.**

The EHR is the chassis upon which the new delivery and payment models established under MACRA must be built. As such, it is important that the “EHR chassis” be reliable, stable, and built to ensure safe navigation. The AAFP and our members have embraced the promise of the EHR for more than a decade, but we continue to reject the complexity of the regulatory structure that governs its use in the Medicare and Medicaid programs. As you know, physicians’ attitudes towards their EHRs and the MU program are at historic negative levels. Most family physicians describe the MU program as one that has stopped progress versus a program that has facilitated it. In a recent survey conducted by the AAFP, greater than 80 percent of family

physicians told us that the EHR is an "obstacle to their success in value-based payment programs." If CMS shares our belief that EHRs should be the chassis, then these findings should be as startling for the agency as they are for the AAFP.

CMS has a renewed opportunity to ensure that EHRs are tools that improve the patient experience of care, improve the health of populations, and reduce the cost of health care**. The AAFP implores CMS to ensure that the MACRA implementing regulations facilitate the use of EHRs and electronic health information in a meaningful way for patients and their physicians.**

The AAFP believes the MU program needs to be replaced with a more appropriate system. We have stated our many concerns with the program:

- It currently adds more burden than benefit to patient care.
- It lacks alignment with the requirements envisioned in the MIPS.
- It needs to place a much stronger focus on interoperability to further accelerate work in that domain.

We believe the "something better" needs to focus on:

- Accelerating robust interoperability to support continuity of care and care coordination,
- Eliminating burdensome requirements on practices that will siphon resources away from caring for patients, and
- Integrating the numerous other initiatives and regulations governing patient care by the federal government, which currently add significant administrative complexity and have begun to interfere with how family physicians improve the care they provide to their patients.

Primary care is a finite resource, which is currently under-valued and under-resourced. Our patients and our nation desperately need health care policy that will enhance efficiency, complement workflow, and improve our ability to deliver the best patient care. We are not alone in believing the current MU program and its criteria do not embody these principles.

Per Beneficiary Primary Care Physician Payments and Care Management Fees

The AAFP recently commissioned a study to determine the value of care management services in primary care practices. The best and most recent research suggests that care management can reduce the total cost of care, on average, by $16.73 PPPM. The value for a given patient will vary widely based on health status and other factors, hence the need to risk-adjust care management fees. Given this value, CMS can achieve a positive return on investment for care management fees at or above the average $15.00 PPPM paid under the CPC initiative.

As a result, the AAFP concurs with the MedPAC recommendation to establish a risk-adjusted, per-patient per-month (PPPM) care management fee for primary care practices that are not otherwise participating in the CPC initiative. The AAFP believes that care management, including chronic care management, is better handled as a PPPM payment within a blended payment model rather than as a CPT code paid as fee-for-service.

By providing more effective care for patients in an ambulatory setting, practices can prevent the deterioration of patients' health that leads to potentially avoidable utilization, particularly costly emergency department visits and admissions to the hospital. A study by van Hasselt and colleagues found that primary care practices offering care management also create savings by

admitting patients to lower cost hospitals. Thus, paying for care management can reduce total cost of care both by reducing unnecessary utilization and encouraging more cost-effective decisions about treatment. **The AAFP therefore urges CMS to recognize the cost savings potential that primary care physicians provide and offer a PPPM care management fee in addition to FFS as a way to help control the total cost of care as per the CPCI model.**

Core Performance Measures

More than any other specialty, family physicians are disproportionally impacted by the burden of quality measurement because of the range and complexity of conditions they treat. A 2016 study in *Health Affairs* found that the average annual amount spent per physician per year on quality measurement across all specialties was $19,494; however, for primary care physicians the average was $22,049 – more than cardiology or orthopedics. This burden is further compounded by the lack of measure alignment across payers and the variety of specifications adopted by payers on similar clinical topics.

The AAFP appreciates CMS' recognition of these issues and stated effort to promote measure alignment and harmonization. Along with America's Health Insurance Plans (AHIP) and CMS, the AAFP has been an active partner in the Core Quality Measures Collaborative, and **we strongly recommend that CMS utilize and implement the Core Measure sets agreed to through the Collaborative for inclusion in MIPS and APMs.**

In our letter dated February 29, 2016, the AAFP provided detailed comments to CMS on the agency's draft quality measure development plan titled, "Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)." We urge you to give these points serious consideration as you decide how to balance the important goal of ensuring meaningful and accurate quality measurement with the disproportionate administrative burdens of measurement on family physician practices.

Patient Attribution

The AAFP encourages CMS to use the prospective attribution methodology employed in the CPC initiative for MACRA programs. Prospective attribution dramatically increases patient engagement with a usual source of primary care and does not have to limit patient choice. In addition, providing physicians with a prospective list of patients for which they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome, because it is challenging for physicians to engage in effective population health management if they do not know which patients need to be targeted for delivery, management, and coordination of care.

The AAFP also urges CMS to include a reconciliation process in its adopted methodology. Under such a reconciliation process, a family physician should be able to review and dispute the list from CMS. This element is currently lacking in the CPC's attribution methodology.

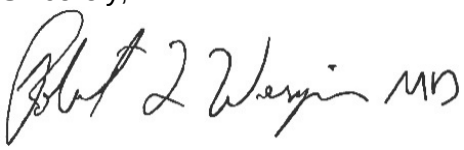
Clinical Practice Improvement Activities

Within the MIPS pathway, the AAFP encourages CMS to offer physicians multiple options for completing clinical practice improvement activities (CPIA). If a practice is a certified PCMH, then CMS should immediately provide this practice with the maximum CPIA score and not require further verification from the practice. If an Eligible Provider (EP) completes an accredited performance improvement Continuing Medical Education (CME) activity as defined by the AAFP, American Medical Association/Accreditation Council for Continuing Medical Education,

American Osteopathic Association, American Academy of Physician Assistants, or other nationally recognized credit systems then CMS should immediately provide this practice with substantial points toward the score for the CPIA Performance Category and require no further verification from the practice. However, if the practice is not a recognized PCMH, and the EP has not completed accredited CME during the time frame under evaluation, then other options could be considered for completion of CPIA.

We appreciate your attention to primary care policies that are critical to the successful implementation of MACRA and request a response to these recommendations. For any questions you might have, please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



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