AAFP

STRONG MEDICINE FOR AMERICA

GOVERNMENT AFFAIRS UPDATE

AAFP Government Relations — 1133 Connecticut Avenue, NW (Suite 1100) — Washington, DC 20036

August 19, 2016

IN THIS SPECIAL RECESS REPORT…

1. AAFP Comments on 2017 Proposed Medicare Physician Fee Schedule
2. Patient Relationship Categories and Codes Subject of AAFP Letter to CMS
3. AAFP to CMS: Patient Experience Measures Should Not Impact Payments
4. CMS Replies to AAFP on Diabetic Testing Supplies
5. AAFP Comments On Opioid Use Disorder Regulation
6. Family Physicians Nominated to Government Advisory Committees

COMING UP IN WASHINGTON…
* Congress has adjourned until September 6.

1. AAFP COMMENTS ON 2017 PROPOSED MEDICARE PHYSICIAN FEE SCHEDULE
In a letter sent to the Centers for Medicare & Medicaid Services (CMS) on August 19, the AAFP responded to proposed rule titled, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model.” Comments on this proposed rule are due September 6.

The letter expressed appreciation that that the proposed rule continues a multi-year effort on the part of CMS to both prioritize and promote primary care as foundational to the Medicare program. The AAFP continued to assert that, to truly realize the value of family medicine and primary care, public and private payers cannot simply rely on delivery system reforms. Since Alternative Payment Models (APMs) and the Merit-Based Payment Incentive Payment System (MIPS) are built on fee for service, it is imperative to fix problems with fee for service and the AAFP appreciated that CMS is taking steps in that direction. Instead, CMS and private payers must make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care.

The AAFP letter recognized that CMS has made a commitment to improving payments for family medicine through the 2017 proposed Medicare physician fee schedule (PFS) and that proposed changes are estimated to result in approximately $900 million in additional funding to primary care physicians. The AAFP urged CMS to maintain these payment changes in the final rule. To improve the final 2016 Medicare physician fee schedule rule, in summary the AAFP:

- Agreed with CMS’s use of an average of the three most recent years of available Medicare claims data as the best way to determine the specialty mix assigned to each code.
- Supported revisions to policies that create unnecessary barriers to the responsible and appropriate use of telemedicine services.
- Applauded CMS for its diligence in identifying and reviewing potentially misvalued codes.

- Recognized that evaluation and management (E/M) services are undervalued relative to procedural services, especially procedures with 10- and 90-day global periods and expects CMS to hold providers of global surgical services to the same documentation standards and guidelines as providers of E/M services when providing a visit.
- Appreciated that this proposed rule continues a multi-year effort on the part of CMS to both prioritize and promote primary care as foundational to the Medicare program, especially since APMs and MIPS are based on fee for service.
- Acknowledged that CMS estimates there will be no “Target Recapture Amount” by which to reduce payments made under the PFS in 2017.
- Noted CMS’s efforts use more current data in all three Geographic Practice Cost Indices.
- Continued to support CMS in its efforts to adjust work relative value units (RVUs) commensurate with changes in intra-service and total time, as well as post-operative visits, despite Relative Value Scale Update Committee (RUC) recommendations to the contrary.
- Supported CMS’s proposals to pay separately for complex chronic care management services and to pay for the codes in this family consistent with the RUC-recommended values and practice expense inputs.
- Expressed ongoing, significant concerns about the disproportional burden primary care physicians will face when trying to comply with Appropriate Use Criteria (AUC) requirements and therefore, strongly urges CMS to delay the implementation of this program so that AUC would be aligned with the forthcoming MIPS program in 2019, versus being introduced as a stand-alone program.
- Fully supported the expansion of the Medicare Diabetes Prevention Program.
- Strongly supported that patients be prospectively assigned a primary care physician or provider along with a simple process for the beneficiary to change the physician or provider to whom he or she was attributed. This approach promotes patient engagement and empowers beneficiaries and their families in directing their care.
- Supported CMS effort to create ways to resolve them as the agency gains experience with collecting data used to calculate the value modifier.

2. AAFP SENDS COMMENTS ON PATIENT RELATIONSHIP CATEGORIES AND CODES

In an August 12 letter to CMS, the AAFP responded to the patient relationship categories and codes document posted by the agency. The letter reiterated AAFP’s support to implement the *Medicare Access and CHIP Reauthorization Act* (MACRA), which requires the establishment and use of patient relationship categories and codes furnished by a physician or applicable practitioner on or after January 1, 2018. The AAFP letter called on CMS to provide additional information on how these patient relationship categories and codes will be used to attribute cost and patient outcomes to physicians and also how this information will be used related to episode groups. The letter stated that it will be essential for CMS to pilot test thoroughly these patient relationship categories before their use impacts payments. The AAFP called on CMS to minimize the reporting burden for physicians and for the agency, through pilot testing, to address logistical issues and possible unintended consequences, especially for small practices.

3. PATIENT EXPERIENCE MEASURES SHOULD NOT IMPACT PAYMENTS

In a letter sent to CMS on August 4, the AAFP urged the agency to utilize patient experience measures only for the purposes of providing payment incentives and not for the purposes of implementing financial penalties. The letter stated the belief that the lack of maturity in patient satisfaction resources supports our position and that CMS should not establish financial penalties for factors outside of a physician’s control, such as lack of patient engagement for completing a patient experience survey. The AAFP called on CMS to apply patient experience measures in a way which distinguishes clinically significant differences in scores from purely statistical differences. Only statistically and reliably valid data should be used in value-based payment programs and publicly reported.

4. CMS REPLIES TO AAFP ON DIABETIC TESTING SUPPLIES

On July 20, CMS sent the AAFP a letter in response to an AAFP letter sent on April 13 requesting relief from the burdensome Medicare requirements associated with the prescribing of diabetic supplies and to discuss growing concerns with the efficacy of unbranded diabetic testing supplies. The CMS response requested a meeting with AAFP to discuss ways to minimize documentation requirements while maintaining the integrity of the Medicare trust funds. CMS also requested more information on the subject of stopping DME suppliers from contacting beneficiaries in an unsolicited manner. CMS suggested AAFP provide detailed information about our concerns with specific products directly to the FDA. The AAFP will continue working with CMS and the FDA regarding these issues.

5. AAFP COMMENTS ON OPIOID USE DISORDER REGULATION

The AAFP sent the Substance Abuse and Mental Health Services Administration (SAMHSA) a letter on August 5 responding to a regulation titled, “Medication- Assisted Treatment (MAT) for Opioid Use Disorders Reporting Requirements.” The AAFP expressed concern that the administrative burden of additional reporting requirements will be a deterrent to expanded medication-assisted therapy for opioid use disorders. In order to streamline reporting, the AAFP strongly urged SAMHSA to examine whether claims data could be used as source for meeting some of the reporting requirements. Claims data for patients using insurance should be piloted by SAMHSA as a way to collect the necessary information without imposing additional reporting burdens on MAT prescribers before these reporting requirements are implemented. The AAFP also strongly suggested that information also be collected regularly from Prescription Drug Monitoring Program data to ensure compliance.

6. AAFP NOMINATES FAMILY PHYSICIANS TO GOVERNMENT ADVISORY COMMITTEES

- On July 20, the AAFP nominated Goutham Rao, MD to serve on a clinical committee to provide input on the development of episode-based resource use measures to meet the requirements of MACRA.
- On July 27, the AAFP nominated Drs. Evelyn Lewis&Clark and Karen O'Brien to serve on the Advisory Committee on Women Veterans
- On July 27, the AAFP sent a letter to the Office of Minority Health in the Department of Health and Human Services that nominated Margot L Savoy, MD to serve on the Advisory Committee on Minority Health
- On August 3, the AAFP nominated Mark Ebell, MD, Michael LeFevre, MD, MSPH, and Elizabeth (Betsy) Rosenblum, MD to serve on the Centers for Disease Control and Prevention’s Advisory Committee to the Director.
- On August 10, the AAFP sent the Centers for Disease Control and Prevention a letter nominating Ranit Mishori to serve on the Healthcare Infection Control Practices Advisory Committee.