AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

October 10, 2013

The Honorable Kathleen Sebelius
Secretary
Department of Health & Human Services
Hubert H. Humphrey Building
Office of Documents and Regulations Management
200 Independence Avenue, SW., Suite 639G
Washington, DC 20201

Re: Request for Information on HHS Retrospective Review 2013

Dear Secretary Sebelius:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 110,600 family physicians and medical students nationwide, I write in response to the HHS request for information titled HHS Retrospective Review 2013 and as published in the September 13, 2013, *Federal Register*.

We appreciate that HHS is continuing to take steps in response to Executive Order 13563. In this latest request for information, HHS now seeks suggestions regarding rules HHS should consider reviewing to:

- Promote economic growth, innovation, competitiveness, and job creation;
- Reduce regulatory and administration burdens;
- Achieve better results by modifying, streamlining, expanding, or eliminating rules when the costs or benefits are greater than originally anticipated;
- Eliminate rules that are outdated, overtaken by new technology or information, or unnecessary for other reasons; or
- Update rules to complement other federal agency rules or international standards where crosscutting collaboration can reduce administration or regulatory burdens.

To the first request, we believe more appropriate payments for family physicians are critical in achieving better care for individuals, better health for individuals, and reduced expenditure growth. We also believe that producing more family physicians helps to develop economic growth while also addressing the clinical needs for the influx of patients receiving insurance through Medicare, Medicaid, Children's Health Insurance Program, Marketplaces, and also private insurers. In order to attract more medical students into the family medicine profession, we urge HHS to consider the innovative primary care physician payment recommendations outlined in our August 29, 2013 letter sent to CMS in response to their proposed 2014 Medicare Physician Fee Schedule as well as our March 27, 2013 letter to CMS. Both letters argue that the complexity of the ambulatory evaluation and management

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(E/M) services that primary care physicians must "fit" into the time available for the typical patient visit is sufficiently distinct to merit dedicated codes and higher relative values than are currently assigned to existing office or other outpatient E/M codes. The AAFP supports a concept called "complexity/density" to describe and quantify this reality. We continue to recommend that HHS create separate primary care E/M Healthcare Common Procedure Coding Systems (HCPCS) codes for office or other outpatient services to new and established patients with correspondingly higher relative values. Adopting these primary care physician payment recommendations should begin to address the looming shortage of primary care physicians and will improve the delivery of healthcare in America.

In response to HHS's request to streamline or reduce regulatory and administrative burdens, the AAFP appreciates that HHS seeks public input, since regulations are often prone to unintended consequences, many of which place unfunded financial mandates on physicians and the medical practice businesses that employ them. We urge HHS to carefully consider the following recommendations, many of which were previously outlined in separate AAFP regulatory comment letters sent to HHS on June 29, 2011, December 7, 2011, and May 8, 2013.

ICD-10 will be costly and disruptive:
While the AAFP appreciates the delayed implementation of ICD-10, family medicine practices must still comply by October 1, 2014. The AAFP continues to prepare our members for this transition yet we are still concerned it will create a significant burden on the practice of medicine with absolutely no direct benefit to individual patient care. Implementing ICD-10 requires physicians and their office staff to contend with 68,000 outpatient diagnostic codes and will require a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. Per a letter sent December 20, 2012, the AAFP and other physician organizations continue to call on HHS to stop implementation of ICD-10 and avoid placing this burden on physicians who are already navigating multiple Medicare incentive programs based on ICD-9.

Costs of Translator Services:
Since 2000, CMS has required that physicians provide translators for Medicare and Medicaid patients with hearing impairments or limited English proficiency. The AAFP supports the effort to ensure successful physician-patient communications, since such communications are critical to favorable healthcare outcomes. However, medical translator services are costly, and neither Medicare nor Medicaid compensates physicians for providing these services. In contrast, Medicare Advantage (Part C) plans are required to cover the cost of translator services for their enrollees. The AAFP strongly believes that HHS should permit interpreters to bill Medicare, Medicaid, CHIP, and health plans operating in the federal and state Marketplaces for their services and, if applicable, treat this as a change in law and regulation for purposes of the physician payment update formula.

Time wasted on prior authorization paperwork:
Another significant unfunded mandate burdening family physicians is the frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorization from public health plans, such as those under Medicare Parts C and D. Frequent formulary changes by the health plan and their time-consuming pre-authorization requirements impede the practice of medicine. The AAFP suggests that HHS provide physician payment

for prior authorizations that exceed a specified number or that are not resolved within a set period of time; prohibit repeated prior authorizations for ongoing use of drugs and supplies by patients with chronic disease; prohibit prior authorizations for standard and inexpensive drugs; and require that all plans use a standard prior authorization form.

Overlapping documentation and certification:
In trying to detect, prevent, and apprehend the criminals that attempt to fraudulently bill public programs, HHS subjects all physicians to multiple and often overlapping documentation and certification requirements. Each day, family physicians spend enormous amounts of time completing a wide range of certification paperwork for home health services and durable medical equipment. Navigating these requirements successfully takes considerable time away from patient care. Instead of treating all physicians as if they are criminals until proven otherwise, the AAFP suggests HHS develop comprehensive yet understandable policies that first target individual providers who are repeat offenders, and we urge HHS to reevaluate the disorganized Medicare documentation and certification requirements.

Inconsistent Claims Review Processes:
Medicare physicians are currently subject to claims review by multiple HHS contractors including Medicare Administrative Contractors (MAC), Medicare and Medicaid Recovery Audit Contractors, Medicaid Integrity Contractors (MIC), Comprehensive Error Rate Testing Contractors (CERT), and Zone Program Integrity Contractors (ZPIC). Additionally, they find themselves subjected to review by Medicare Advantage plans seeking to validate the risk adjustment scores those plans receive from Medicare. These redundant, inconsistent, and overlapping audits place an enormous administrative burden on practicing physicians, and the AAFP urges HHS to streamline and coordinate these efforts.

Need for Administrative Simplification:
The AAFP was pleased that the *Affordable Care Act* (ACA) included significant administrative simplification provisions that, once regulations are promulgated and finalized, will begin to help reduce some of the burdens physicians cope with daily when interacting with both public and private health insurers. HHS should immediately implement these provisions to reduce administrative hassles.

Improving the Medicare enrollment process:
Perhaps the largest and most persistent source of physician frustrations stemming from burdensome Medicare rules is the time consuming Medicare enrollment process. CMS annually conducts the Provider Contractor Satisfaction Survey, and physicians' experience with the Medicare enrollment process continues to rank at or near the bottom. All too often physicians wait several months for CMS contractors to process an enrollment application, and these delays cause severe financial hardships for their practices. The AAFP continues to urge CMS to promptly and drastically improve the Medicare physician enrollment process.

Reevaluating Medicare signature requirements:
Our members believe that the Medicare signature requirements placed on physicians are overwhelming compliance burdens and unnecessarily time consuming. Consequently, we would ask CMS to reevaluate those requirements. Physicians rely to a great extent on staff members who handle incoming mail and often large volumes of record requests to assist them in complying with Medicare and other payers' additional documentation requests

(ADRs). Physicians and their staff would benefit from more complete instructions with each request initiated by a CMS contractor.

Relief from the burdensome and requirements of prescribing diabetic supplies
The AAFP believes HHS should simplify Medicare rules surrounding prescription of diabetic supplies without compromising the integrity of the Medicare program. Diabetes is one of the most common, costly, and deadliest of chronic illnesses, and patients with diabetes need diabetic testing supplies to care for themselves adequately. Difficulty in obtaining diabetic supplies leads to poorer health outcomes for patients. Family physicians simply want to prescribe efficiently and effectively what their diabetic patients need to help manage their condition. Unfortunately, the current Medicare rules for prescription of diabetic supplies impede this goal and add no discernible value to the care of such patients. Specifying "length of need" on a prescription is questionable since diabetes is a chronic disease with no known cure. Patients with diabetes need glucose testing supplies for as long as they are able to care for themselves in their own home. Ideally, it should be acceptable for a physician to write for "diabetic supplies," which would include syringes, needles, test strips, lancets, glucose testing machine, etc., with only a need to provide a diagnosis and an indication such a prescription is good for the patient's lifetime. As long as physicians are clear in describing the frequency, they should be able to write the generic terms for these items without having the hassle of knowing exactly which one is on the formulary of a particular health plan. Family physicians' time is better spent helping patients manage their diabetes, not providing additional paperwork to justify what the patient needs for such a basic service in diabetes.

In closing, we again offer our support to HHS for continuing to retrospectively review existing rules. We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Jeffrey J. Cain, M.D., FAAFP
Board Chair