AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 29, 2011

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: Reducing Regulatory Burden; Retrospective Review under Executive Order 13563

Dear Secretary Sebelius:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I am writing in response to the request for comment on the U.S. Department of Health & Human Services' (HHS) Preliminary Plan for Retrospective Review of Existing Rules as posted online May 18, 2011. This plan is in accordance with Executive Order 13563 that was issued by President Obama on January 18, 2011. The AAFP appreciates that the White House and HHS recognize the importance of a streamlined, effective, and efficient regulatory framework as a way to help achieve economic growth, job-creation, and competition.

As stated in Executive Order 13563, the purpose of the HHS preliminary plan is to identify a preliminary list of regulations that are appropriate candidates for review over the next two years and establish an ongoing process of retrospective review of existing regulations by which HHS can determine whether any should be modified, streamlined, expanded, or repealed.

To respond to the executive order, AAFP members participated in the American Medical Association (AMA) survey to identify the most burdensome regulations with which they deal, along with any recommendations for how the regulations could be improved. The AAFP supports this AMA effort and offer the following additional comments.

Many HHS regulations are based on important goals that improve patient access to services, increase the quality of care offered, and modernize the practice of medicine through the expanded use of health information technology. In general, the AAFP supports the goals of most HHS regulations. However regulations are often prone to unintended consequences, many of which place unfunded financial mandates on physicians and the medical practice businesses that employ them. Because family physicians and other primary care physicians provide a broad range of healthcare services to Medicare, Medicaid, Children's Health Insurance Program, and private insurance patients, many of these well intended goals particularly disadvantage primary care practices. According to the AMA survey, three out of five physicians selected their top regulatory grievances to be associated with unfunded mandates. The following were identified as particularly burdensome requirements:

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Costs of Translator Services:
Since 2000, physicians have been required to 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 achieve favorable healthcare outcomes. However, medical translator services are costly, and neither Medicare nor Medicaid compensates physicians for providing these services. Considering that Medicare Advantage (Part C) plans are required to cover the cost of translator services for their enrollees, the AAFP strongly believes that CMS should permit interpreters to bill Medicare and Medicaid 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 are the frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorization from a Prescription Drug Plan (Part D) or a Medicare Advantage Plan (Part C). Frequent formulary changes by the health plan and their time-consuming pre-authorization requirements impede the practice of medicine. The AAFP suggests that CMS require Part D and Part C plans to reimburse physicians 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 a drug 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 the Medicare and Medicaid 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 Medicare and Medicaid billing physicians as if they are criminals until proven otherwise, the AAFP suggests CMS develop comprehensive yet understandable policies that first target individual providers who are repeat offenders and we urge CMS to reevaluate the disorganized Medicare documentation and certification requirements.

Modernizing the Medicare Economic Index:
In the 2010 Medicare physician fee schedule, CMS discussed the need to modernize and increase the Medicare Economic Index (MEI) to reflect 21st century medicine. The AAFP appreciates that CMS recognized this issue, since the MEI significantly understates the true operating costs borne by medical practices, but the AAFP would be even more appreciative if CMS actually proceeded to update the MEI so it reflects the true costs of practicing medicine. Updating the MEI would help to reduce uncertainties associated with physician participation in the Medicare program.

Harmonizing Incentive Programs:
Another way to successfully address HHS regulatory burdens felt by family physicians would be to harmonize all of the codes, quality measures, operating rules, feedback reports, and timelines associated with the Physician Quality Reporting System (PQRS), Medicare electronic prescribing incentive program, and the Medicare and Medicaid electronic health records (EHR) incentive programs. Since each program was created piecemeal by separate laws, physicians are frustrated and confused by the several inconsistencies within these incentive programs. The AAFP recognizes that HHS has already taken steps to align these programs, and we urge HHS to continue further with these efforts.

Section 3002(e) of the ACA requires HHS to provide timely feedback to physicians on their performance with respect to satisfactorily submitting data on the PQRS quality measures. It is disappointing that CMS did not

take steps to implement this timely feedback requirement in the 2011 Medicare physician fee schedule. Issuing feedback reports 7-10 months after the reporting period is hardly timely, and we urge CMS to address this shortcoming.

Inconsistent Claims Review Processes:
Medicare physicians are currently subject to claims review by multiple HHS contractors including Medicare Administrative Contractors (MAC), Medicare (and soon also 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 better 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. It is quite perplexing to the AAFP that some of the administrative simplification provisions within the ACA were identical to provisions signed into law in 1996 with enactment of the Health Insurance Portability and Accountability Act (HIPAA). For example, the provision requiring HHS to develop a unique health plan identifier, which will greatly streamline the billing process for both physicians and for health plans, is in both the ACA and HIPAA. Fourteen years after passage of the HIPAA, HHS still has not promulgated implementing regulations for the unique health plan identifier. As a means to reduce administrative hassles, the AAFP urges CMS to promptly issue regulations fully implementing all administrative simplification provisions.

Improving the Medicare enrollment process:
Perhaps the largest source of physician frustrations stemming from participating in the Medicare program 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, and consequently, we would ask CMS to re-evaluate those requirements. Physicians rely to a certain extent on staff who handles 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. Specifically, the AAFP is concerned with the following instructions given to Medicare contractors in Change Request 6698:

- CMS **requires** Comprehensive Error Rate Testing contractors to use language in their ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document, but CMS only **encourages** other contractors to do the same. (Emphasis added.) The AAFP believes this should be required for all contractors including the Recovery Audit Contractors.
- In addition, all reviewers have the discretion to add language to their ADRs stating that the physician is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer notices a note with a missing or illegible signature, the ADR may inform the provider that they may submit a signature log or signature attestation as part of the

ADR response. The AAFP believes this language should be required, rather than discretionary, so that physicians and their staff are fully informed of the opportunities to authenticate their documentation.

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,

Lori J. Heim, MD, FAAFP
Board Chair