December 22, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1654–F
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write with the Academy's reaction to the final rule titled, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 as published by the Centers for Medicare & Medicaid Services (CMS) in the November 15, 2016, *Federal Register*.

The AAFP appreciates that CMS has created new primary care codes and initiated payment for other codes previously bundled as a step toward reinforcing primary medical care and Americans' access to high-quality health care, but more must be done. Without a strong primary care foundation, the fragmentation, duplication and unnecessary costs that have plagued America's health care system will continue despite efforts to increase quality of care. To truly realize the value of family medicine and primary care, public and private payers cannot simply rely on delivery system reforms, but must also appropriately value the delivery of primary care services.

The complexity of care provided by family physicians is unparalleled in medicine. Data demonstrates that family physicians address more diagnoses and treatment plans per visit than any other medical specialty. Furthermore, the number and complexity of conditions, complaints, and diseases seen in primary care visits is far greater than those seen by any other physician specialty.

Since the Merit-Based Incentive Payment System (MIPS) is built on fee for service, it is imperative to address misvalued services, particularly the undervaluation of primary care services. In addition, 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.

We recognize that a robust and well-financed health care system built on primary care is a goal that CMS also strongly supports. Primary care is particularly affected by longstanding inequities in payment that must 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 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 agrees with the article and report. Drastic payment discrepancies continue to raise serious concerns about fee schedule mispricing and its resulting negative impact on primary care. 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.

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 and 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. These changes to payment for primary care services are especially critical to MACRA's success – as the foundation of the new Quality Payment Program (QPP) is still Medicare fee for service.

Though CMS is not seeking further public comment on this Medicare physician fee schedule, the AAFP offers these recommendations to assist with future rulemaking.

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 and on October 17, 2016, new and costly limited English proficiency policies went into effect. 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 consistently 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. CMS should create a G-code that is comparative to the State Medicaid recognized T1013 code ((sign language or oral interpretive services, per 15 minutes) to allow for billing of these services.

Achieve the target recapture amount

The AAFP remains deeply disappointed that CMS only finalized misvalued code changes that achieve 0.32 percent in net expenditure reductions and that the 2017 Medicare Physician Fee Schedule conversion factor will be $35.89, an increase of only nine cents from the 2016 conversion factor. These changes do not fully meet the misvalued code target required by law; therefore, physicians will not receive the positive 0.5 percent update in 2017 that was promised under the *Medicare Access and CHIP Reauthorization Act* (MACRA).

For a variety of reasons, primary care services remain undervalued relative to procedural services under the Medicare physician fee schedule. When CMS applies the target recapture amount to all physician services, as it did in 2016 and will again in 2017, it only exacerbates the disparity.

Going forward, we suggest CMS expeditiously study and reduce payment for procedures with 10- and 90-day global periods and hold providers of global surgical services to the same documentation standards and guidelines as providers who bill evaluation and management (E/M) services. Global surgical packages are inflated in terms of the number and level of post-operative visits assumed to be included and incorporated in the value of the codes in question. We also note that the current arrangement leads to unwarranted payment disparities in practice expense values between E/M services in a global surgical package and stand-alone E/M services. We note that who is providing these services is also an issue; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeon focuses only on the surgery itself. Under current Medicare payment rules, such visits would be paid at a discounted rate if reported separately by the NPs and PAs (assuming "incident to" rules were not met); however, these visits are valued at the full physician rate in the global surgical package, even when the visits take place in a hospital (where "incident to" does not apply). Finally, there may also be issues with the pre-operative work involved, especially for procedures with 90-day global periods. Our members report that surgeons often request "clearance for surgery consults" from family physicians and other primary care physicians, often driven by hospital requirements. However, the definition and value of the global surgical package appears to require that the surgeon clears the patient for the surgery in terms of health risk. The surgeon should also perform any pre-requisite testing. In the experience of family physicians, this rarely occurs. We continue to believe that the current global surgical packages are incompatible with current practice and provide unreliable building blocks for new payment methodologies. The AAFP strongly urges CMS to continue efforts to pay accurately for surgical services.

Since the agency did not reduce overvalued RVUs to the levels required by law, CMS should have taken steps to reduce the impact on primary care services which are known to be undervalued until the agency could meet its statutory requirement. The continuing undervaluation of primary care services in the fee schedule will be perpetuated in the new MACRA quality payment programs if the agency does not act to mitigate and correct these longstanding imbalances.

Despite our deep disappointment in the final rule, the AAFP maintains support for the agency's authority to adjust physician codes in the spirit of more accurately paying for Medicare services. We strongly encourage CMS to aggressively exercise this authority and make necessary adjustments to RVUs. The *Protecting Access to Medicare Act* (PAMA) of 2014, as modified by *the Achieving a Better Life Experience Act* (ABLE) of 2014, requires CMS to meet a target for net reductions in fee schedule expenditures associated with misvalued services for 2018 that is 0.5 percent. We urge CMS to do everything that it can to meet this target, lest the agency once again undermine the increase promised under MACRA.

Address beneficiary cost-sharing for primary care services

While the AAFP welcomes the additional codes for complex chronic care management, mental and behavioral issues, and cognitive impairment, we continue to advocate that patients not be subject to cost-sharing for these and other chronic care management services. Such care management services prevent deterioration of the patient's condition(s), the advent of

complications, and the necessity of emergency department visits and hospital admissions. In this way, they are as much or more preventive services as they are therapeutic and, thus, deserving of similar treatment with respect to waiving Medicare coinsurance and deductible. The AAFP encourages CMS to seek authority to waive the applicable Part B coinsurance and deductible for important primary care services.

Align Appropriate Use Criteria requirements with MACRA

The AAFP is increasingly concerned that CMS is adding regulatory burdens to primary care physicians, such as consulting appropriate use criteria (AUC) for advanced diagnostic imaging. This troubling program will divert resources from patient care and is unproven in efficacy. This represents a significant and new regulatory burden on physicians, particularly primary care physicians, and we therefore urge CMS to compensate physicians for the additional time spent navigating these requirements. The AAFP has ongoing, significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements. We believe these requirements will place more burdens on primary care physicians than on other providers and add an unnecessary level of complexity that severely overtaxes our members. CMS must align the AUC program with the MIPS, since one of the components impacting MIPS payment is a cost category.

The AAFP strongly urges CMS to delay implementation of the AUC provision in the law until such time as the following conditions are met:

- There is evidence to demonstrate that AUC improves quality of care.
- MACRA is fully implemented for a minimum of three years.
- Any AUC requirements are fully aligned with MACRA.
- Sets of AUC for the same diagnostic imaging modality, developed by different provider led entities, are standardized.
- Clinical Decision Support Mechanisms (CDSMs) are fully interoperable with electronic health records (EHRs).
- At least one CDSM with a comprehensive set of AUC, which is fully interoperable with certified EHR technology (CEHRT), is freely available.
- CDSM communicate AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition in an automated manner and do not require any separate action or use by a physician.

Reexamine Structure of E/M Services

CMS should explore the structure 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.

Revise 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 and patient-centered 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 with some exceptions. 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 the Medicare Program Integrity Manual. All documentation guidelines for E&M codes 99211-99215 and 99201-99205 are eliminated for primary care physicians.

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 value-based practice transformation efforts. An AMA-sponsored landmark RAND study noted that most physicians surveyed shared the opinion that EHR systems fail to support efficient and effective clinical work. Study findings noted for many physicians, “the current state of EHR technology significantly worsened professional satisfaction in multiple ways. Aspects of current EHRs that were particularly common sources of dissatisfaction included poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information, and degradation of clinical documentation.” The AMA and MedStar Health partnered to evaluate reported vendor use of user-centered design (UCD), for health IT capabilities required by the ONC for the Meaningful Use Program. Findings highlighted a very narrow focus on use of UCD principles in that of the dozens of required health IT capabilities, only eight capabilities require vendors to report on the UCD processes followed, and adherence to UCD best practices is not a requirement of certification.

A September 2015 EHR usability study (Ratwani et al., 2015), published in the Journal of the American Medical Association, indicates opportunities for improvement in documenting vendor compliance with user-centered design principles during testing and certification of health IT

through the ONC Health IT Certification Program. In a review of vendor reports and testing results published on ONC's Certified Health IT Product List (CHPL), Ratwani's research team pulled reports of health IT products meeting the 2014 edition certification requirements for the 50 EHR vendors with the highest numbers of providers (hospitals and small practices) attesting to meeting meaningful use requirements with that product between April 1, 2013 and November 30, 2014, which Ratwani noted represented greater than 90% of provider attestations during that period. Of those 50 certified vendors, 41 reports were available for review (82%) and of those 41 reports, Ratwani notes 14 (34%) had not met the ONC certification requirement of stating their UCD process (Figure 1), 19 (46%) used an industry standard, and 6 (15%) used an internally developed UCD process. Ratwani's findings noted variability in the number of participants enrolled in usability tests, although the supported standard calls for 15 participants for UCD testing. Of the 41 vendor reports, 26 (63%) used less than the supported standard of 15 participants for UCD testing (Figure 2) and only 9 (22%) used at least 15 participants with clinical backgrounds. One of the vendors used no clinical participants, 7 (17%) used no physician participants, 2 (5%) used their own employees for UCD testing. Five (12%) of vendor reports lacked sufficient detail to determine whether physicians participated in UCD testing, and 21 vendors (51%) did not provide required demographic details.

In summary, 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. We 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 clinician needs and workflows within the transformed practice environment. Furthermore, we call on ONC and CMS to place the burden of compliance on the vendors and not on physicians. EHR vendors must be held accountable for the inadequate design and poor usability of their products, not the physicians who struggle to use these products in their practices.

Improve the Annual Wellness Visit

Under the advance care planning subheading titled, "Who Can Furnish/Setting of Care," CMS, it states that advance care planning is primarily the responsibility of patients and physicians and that the agency expects the billing physician or non-physician provider to manage, participate, and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision. The AAFP wholeheartedly agrees with this response.

We therefore strongly recommend this statement and policy should also be applicable to Annual Wellness Visit services (AWV). In an April 30, 2015, letter from the American Academy of Family Physicians, and other physician organizations, we articulated our concern about the potential misuse of the AWV by commercial entities. The AAFP maintains that the AWV encourages Medicare beneficiaries to engage with their primary care physician or other usual source of care on an annual basis for prevention and early detection of illness, and we are still concerned that there are commercial entities that are subverting that benefit and may be misleading patients.

As with the advance care planning services, we urge CMS to specify that annual wellness visits are primarily the responsibility of patients and physicians and that the agency expects the billing physician or non-physician provider to manage, participate, and meaningfully contribute to the ongoing provision of services to the patient, in addition to providing a minimum of direct

supervision. Such requirements for the AWV are consistent with the tenets of continuity of care, which is rooted in a long-term patient-physician partnership in which the physician knows the patient's history from experience and can integrate new information, such as that obtained from an annual wellness visit, and decisions from a whole-patient perspective.

Transitional Care Management Services
Communication and electronic health record (EHR) interoperability barriers continue to hinder the uptake of transitional care management services (TCM). 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 the ability of family physicians to 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.

Quality Measure Harmonization and Alignment
The AAFP believes more work must be done to harmonize quality and performance measures. 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 measurement. 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 utilize the MACRA Annual Call for Quality Measures as part of their overall approach to reducing administrative burden. To accomplish this, the AAFP recommends that CMS 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.

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 Medicare Advantage Plan (Part C) or for a durable medical equipment supplier. Frequent formulary changes by drug and health plans 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 pay 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.

Simplifying 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 burdensome documentation and certification requirements. Family physicians spend unwarranted and inefficient time completing a wide range of certification paperwork for home health services and durable medical equipment. Navigating these requirements successfully robs time from patient care. The AAFP suggests CMS develop comprehensive yet understandable policies that first target individual providers who are repeat offenders, and we urge CMS to reevaluate 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 (MACs), Medicare (and soon also Medicaid) Recovery Audit Contractors, Medicaid Integrity Contractors (MIC), Comprehensive Error Rate Testing Contractors (CERT), and Zone Program Integrity Contractors (ZPICs). 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 and inconsistent audits place an enormous administrative burden on practicing physicians, and the AAFP urges CMS to better streamline and coordinate these efforts.

Enforce the Health Plan Identifier
The AAFP was pleased that the *Affordable Care Act* 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. The provision requiring CMS to develop a unique health plan identifier (HPID) will greatly streamline the billing process for both physicians and for health plans. As a means to reduce administrative hassles, the AAFP urges CMS to end the delay, announced October 31, 2014, in enforcement of regulations pertaining to health plan enumeration and use of the Health Plan Identifier (HPID).

Reevaluating Medicare signature requirements
Family physicians believe that the Medicare signature requirements placed on physicians create unnecessary compliance burdens and are far too time-consuming. We urge CMS to reevaluate 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.

Social Security Number Removal Initiative
As part of MACRA, CMS will no longer be allowed to use social security numbers to identify Medicare beneficiaries. They will instead begin to issue Medicare Beneficiary Identifier (MBI) numbers to all individuals receiving Medicare benefits. This transition will begin April 2018, to be completed January 1, 2019. CMS is currently in a fact-finding phase, conducting stakeholder calls with interested parties and the AAFP has participated in multiple sessions. Making beneficiaries solely responsible for sharing the new MBIs with providers of care and shutting down provider portals will impede physician payment structures as well as patient access to care. The AAFP feels that CMS should review current portals for accessing beneficiary data and develop similar structures.

We 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

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Board Chair