



AAFP's Agenda for Regulatory and Administrative Reforms

Primary care – and particularly family medicine – is foundational to continued progress in reforming our nation's health care system. Family medicine and primary care are delivered by dedicated individual family physicians and their health care teams in urban and rural communities. A majority of family physicians practice in independent solo or small group practices, providing their patients' comprehensive, continuous, coordinated, and first contact primary care in their community.

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.

Many family medicine practices are small businesses, facing the challenges of complying with federal and state regulations as well as requirements imposed by private insurers, while focusing on providing the highest quality of care to patients. A majority of family physician practices have contractual relationships with seven or more payers. This means they must comply with disparate rules and regulations from seven or more payers on a daily basis, which distracts from the family physician's core purpose: caring for patients. The human and financial costs of regulatory compliance have become untenable, forcing far too many family physicians to consolidate or sell their practices.

The American Academy of Family Physician's (AAFP) believes that independent physician practices and groups are important to our health care system, patients and for the communities where they exist. This is why we are calling for a coordinated effort to preserve and promote these practices. At the forefront of this effort is our call for an immediate reduction in the regulatory and administrative requirements these physicians and practices must comply with on a daily basis.

As part of the AAFP's agenda for regulatory and administrative reforms to promoting better primary care by preserving independent primary care practices, we call on the Administration and Congress to significantly reduce the regulatory and administrative burdens on physician practices by acting on the following priorities:

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Prior Authorizations (unfunded mandate)

The frequent phone calls, faxes, and forms physicians and their staffs must manage to obtain prior authorization for an item or service create enormous burden. A large part of that burden stems from these unfunded prior authorizations (PA) requirements. PAs are becoming increasingly common as employers and insurance companies struggle to control escalating pharmaceutical, radiological, and medical equipment costs. Since a majority of family physician practices have contractual relationships with seven or more payers, they must often navigate seven or more different prior authorization rules and forms. The AAFP asks CMS and Congress to eliminate the use of PAs in the Medicare program for generic drugs, create a single PA form that all Medicare Part D plans must use, and further limit or reduce the number of products and services requiring PAs. The AAFP suggests that CMS require Medicare Advantage (Part C) and Part D plans to pay physicians for PAs that exceed a specified number or that are not resolved within a set period of time; prohibit recurrent PA requirements for ongoing use of a drug by patients with chronic disease; prohibit PAs for standard and inexpensive drugs; and require that all plans (public and private) use a standard PA form and process.

Evaluation and Management Services

The current CMS Documentation Guidelines for Evaluation and Management (E/M) Services were written 20 years ago and do not reflect the current use and further potential of electronic health records (EHRs) and team based care to support clinical decision-making and patient-centeredness. These documentation guidelines have resulted in 'clunky' EHRs that have only been designed to document 'bullets for billing' in a fee-for-service payment system rather than the needed focus on patient and population health. The AAFP believes there should be changes in these outdated documentation guidelines as well as the Medicare Program Integrity Manual to make it clear that any documentation entered into the medical record by the team related to a patient's visit would be considered in determining and supporting the submitted code. Most importantly, we strongly recommend that all documentation guidelines for E/M codes 99211-99215 and 99201-99205 be eliminated for primary care physicians.

Translation Service Costs (unfunded mandate)

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. Family physicians already operate on slim financial margins. The AAFP strongly believes that Congress and HHS must procure the necessary funding to address and offset the estimated financial burden on physician practices. We have significant concerns that primary care practices are already taking a financial loss for treating patients that require interpretive services because of the historical undervaluation of primary care services in the resource-based relative value scale system. Medicare and Medicaid payment for essential primary care services are simply inadequate and interpretive services remain costly. If the patient reschedules or does not appear for the appointment, the practice must still pay the interpreter. We believe that HHS must fund the increased costs practices will bear to comply with these requirements. If this cannot be accomplished, we call on HHS to eliminate this requirement.

Quality Measure Harmonization and Alignment

The AAFP believes more work must be done in quality and performance measure harmonization. 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 measures. 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 align quality measures as part of their overall approach to reducing administrative burden. To accomplish this, the AAFP recommends that CMS, in all federal programs and demonstrations, 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.

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 practice transformation. Therefore, all 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. Physicians 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 the transformed practice environment. Furthermore, we call on HHS to place the burden of compliance on EHR vendors and not on physicians. EHR vendors must be held accountable for the inadequate design and poor performance of their products, not the physicians who struggle to use these products in their practices.

Chronic Care Management Documentation

The 2017 Medicare Physician Fee Schedule Final Rule made great strides to simplify the requirements of Chronic Care Management (CCM) regarding consent and access to the care plan. The AAFP believes that the documentation requirements are still excessive and should be further reduced. We also support the elimination of the cost-sharing requirements associated with the service.

Appropriate Use Criteria (AUC) Alignment with MIPS (unfunded mandate)

The AAFP has ongoing, significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements. Much like prior authorization requirements noted above, we believe that AUC requirements will place more burdens on primary care physicians than on other clinicians and add an unnecessary level of complexity to the already complex Medicare system that severely overtaxes our members. The AAFP, therefore, strongly urges CMS to at least delay the implementation of this program, so AUC would be aligned with the forthcoming MIPS program in 2019, versus being introduced as a stand-alone program – in fact, we would prefer that this program and regulatory burden be discontinued completely. With the passage and implementation of MACRA, which begins to align payment with value, the need for AUC requirements has been supplanted, and those requirements will now likely hinder, rather than improve, effective care.

Social Security Number Removal Initiative (unfunded mandate)

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 in April 2018, to be

completed and in full effect by January 1, 2019. 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.

Inconsistent Claims Review

There are a multitude of post-claims review processes: ZPIC, RAC, CERT, Meaningful Use, etc. Within these audit programs, there are a multitude of requirements, appeals processes (if any), differing deadlines, and governing agencies. Communications from these entities are not easily understood by busy physicians nor are their deadlines easy to meet. Monitoring activity is recognized as necessary, however the AAFP strongly recommends that CMS streamline programs and utilize one set of criteria that is universal.

Transitional Care Management Services

Communication and EHR interoperability barriers continue to hinder the uptake of transitional care management (TCM) services. 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 family physicians' ability to provide these important services and 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.