



December 28, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-IFC
P.O. Box 8010
Baltimore, MD 21244-8016

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the [final rules and interim final rule](#), titled “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019” as published by the agency in the November 23, 2018, *Federal Register*.

The AAFP appreciates that CMS has shown a strong commitment to supporting primary care in recent years—and we look forward to working with CMS to share our data, member experiences, and analyses to ensure appropriate valuation of primary care services over the next two years. At the same time, we look forward to working with CMS and its Innovation Center to test and implement sustainable alternative payment models (APMs) for primary care, such as the AAFP’s [Advanced Primary Care Alternative Payment Model](#) (APC-APM). The reality is that fee-for-service (FFS) payment is a barrier to many aspects of primary care transformation and the kind of primary care-based health system this country needs and deserves. **Yet, FFS payment remains the operational payment methodology and is in need of significant improvement to support primary care, especially the valuation of and payment for evaluation and management (E/M) services, as future APMs will be actuarially based upon the framework of FFS payment. Thus, if current FFS payments are not improved, the current undervaluation of family medicine and primary care payment will result in a similar undervaluation of primary care in evolving primary care APMs.** In the long run, Medicare and other payers must find a way to pay primary care practices through APMs that rely less on FFS and more on predictable, prospective, and risk-adjusted per patient per month payments that cover both office/outpatient evaluation and management (E/M) services and non-face-to-face population-based services. Such APMs, properly funded, offer the best hope for true administrative simplification and relief from documentation burdens with the added benefits of better care for patients and lower overall costs to Medicare and the rest of the health care system.

In sum, the AAFP appreciates that CMS recognizes the problems with the current E/M

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documentation guidelines and codes, and we sincerely thank CMS for its desire and intent to address them. **Since CMS has publicly stated that the document that outlines E/M documentation guidelines is not owned or maintained by the agency, the AAFP is further encouraged that Medicare can now fully divorce itself from using these documents for auditing and payment purposes.** Doing so would immediately lessen documentation burdens for primary care physicians. The AAFP is committed to—and supports—payment policies that bolster the delivery of patient-centered primary care that is comprehensive, continuous, coordinated, connected, and accessible. We welcome the opportunity to continue working with CMS and other stakeholders to ensure all Medicare beneficiaries have access to coordinated, longitudinal primary care that improves patient outcomes and reduces health care spending. The AAFP strongly supports streamlining documentation guidelines and reducing administrative burden in all health care programs—both public and private. We urge CMS to continue to use its unique influence to drive action by all payers.

D. 6. Requirements of the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Summary

The SUPPORT Act modifies Medicare telehealth policies by removing the originating site geographic requirements for telehealth services furnished on or after July 1, 2019, for the purpose of treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder. It also adds the home of an individual as a permissible originating site for these telehealth services. This would apply for the treatment of substance use or co-occurring mental health conditions. When an individual is seen at home, there is not an originating site fee. The rule indicated that there may need to be additional sub-regulatory guidance and that the opioids law did not amend Section 1834(m) (4f) that limits the scope of telehealth services on the Medicare telehealth list. CMS requests further comments on these policy changes.

AAFP Response

This policy is consistent with the AAFP's policy recommendations regarding the need to reduce barriers associated with medication-assisted treatment. In the [AAFP's Chronic Pain Management and Opioid Misuse position paper](#), payment and care coordination are identified as two key barriers. While the policy would provide greater flexibility that could ensure greater payment for primary care physicians who provide substance use services for patients, it does not address the need for care coordination, such as with addiction specialists, which may be beneficial for patients.

The policy stresses the need to “encourage and enable physicians to use protocols for medication-assisted treatment (MAT) to address opioid dependence within the clinic population.” It also urges members to “expand cross-coverage opportunities for solo, waived family physicians working in rural and underserved areas, including the possible short-term use of nonwaived physicians to provide coverage.” In order to provide the care needed to all patients with substance use disorder, including opioids, the AAFP would encourage CMS to amend Section 1834(m)(4f) to include MAT and remote opioid treatment as covered services on the Medicare telehealth list.

b. Medicare Payment for Certain Services Furnished by Opioid Treatment Programs

Summary

In accordance with Section 2005 of the SUPPORT Act, CMS issued a request for information regarding a new Medicare benefit category for treatment services by opioid treatment programs (OTPs) under Medicare Part B for services provided after January 1, 2020. Services include

providing FDA-approved opioid treatment using agonist and antagonist medications, counseling, dispensing pharmaceuticals, toxicology testing, and other services determined as appropriate. CMS summarizes an OTP as those enrolled in Medicare, certified by the Substance Use and Mental Health Services Administration (SAMHSA), and accredited by a SAMHSA-approved entity. CMS seeks comments on these programs.

AAFP Response

Increasing access to treatment is an important priority highlighted within the [AAFP's opioid position paper](#). The AAFP recommends that services include coordination with primary care physicians because many patients with substance use disorders often have a myriad of physical health challenges that need to be addressed. The [AAFP's Substance Abuse and Addiction policy](#) prioritizes partnering with community resources in the prevention, education, and treatment of substance abuse and addiction.

Additionally, the [opioid position paper](#) encourages that health care partners, “Increase collaboration among community behavioral health services, nurse care management services, other psychosocial support services, and primary care in order to support community providers of MAT.”

I. Evaluation and Management (E/M) Visits

Summary

In the 2019 final rule, CMS finalized several favorable changes to E/M documentation guidelines that become effective on January 1, 2019. These include:

- Eliminating the requirement to document medical necessity of furnishing visits in the home rather than the office.
- For established patient office/outpatient visits, and when the medical record already contains relevant information, CMS will allow physicians to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and not require physicians to re-record the defined list of required elements. Physicians will still need to review prior data, update it as necessary, and indicate in the medical record that they have done so.
- Allowing ancillary staff to perform and record the chief complaint and history. When they do, physicians only need to document that they reviewed and verified information regarding chief complaint and history already recorded by ancillary staff or the patient.

Payment Policy and Other Documentation Changes

Beginning January 1, 2021, CMS plans to implement a blended payment rate for office/outpatient E/M services visits levels 2-4 while maintaining separate payment rates for levels 1 and 5. For visits at levels 2-4, physicians will only need to document the elements associated with a level 2 visit.

Also beginning January 1, 2021, CMS plans to allow physicians more flexible documentation requirements related to E/M services. Specifically, physicians may document E/M services based on the current E/M visit documentation framework, or they may document solely based on medical decision making (MDM) or time. For time-based coding, physicians will simply need to document that they personally spent the time described by each level of service (as reflected in the typical time printed in the Current Procedural Terminology [CPT] descriptors) face-to-face with the patient.

CMS notes that “the 2-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA [American Medical Association] and the CPT Editorial Panel, as well as other stakeholders. We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes.”

Add-on Codes

In conjunction with its proposal to implement a single payment rate for levels 2-4 office/outpatient visits, CMS plans to implement two add-on codes that could be used with visits at those levels. One will account for the work inherent in primary care office/outpatient visits, and the other will account for the work inherent in office/outpatient visits provided by non-procedural specialties. CMS plans to value the two codes at the same level, and CMS notes it expects certain specialties, like family medicine, would include the primary care add-on code on nearly every visit. CMS believes it would be very rare for a physician to use both add-on codes at the same encounter.

Additionally, CMS plans to implement an add-on code to account for the additional resource costs when physicians or other qualified health care professionals need to spend significantly more time with particular patients at levels 2-4.

Multiple Procedure Payment Reduction

CMS did not finalize its proposal to apply a Multiple Procedure Payment Reduction (MPPR) policy that would have potentially reduced payment by 50% for office visits that occur on the same date as procedures or other services. CMS intends to reconsider the appropriate global period assigned to certain services instead.

AAFP Response

Documentation Relief

The AAFP appreciates that CMS decided to implement some immediate documentation relief for E/M services in 2019. The opportunity to rely on the chief complaint and other history elements documented by ancillary staff is consistent with the team-based model of care used in primary care today. Likewise, the opportunity to rely on relevant information already in the medical record for established patients will allow family physicians to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and avoid re-recording certain elements just for the sake of meeting outdated documentation guidelines.

These changes in policy provide an opportunity over the next two years (2019 and 2020) for CMS to see whether relaxing documentation requirements has an impact on physician coding of E/M services and, if so, how. We hope this natural experiment will reinforce CMS’s intent to provide additional documentation relief in 2021.

In fact, we were disappointed that CMS chose to delay additional documentation changes until 2021. We continue to recommend that CMS decouple its documentation and payment proposals wherever possible. As CMS has previously recognized, there is a need to review and revise the 1995 and 1997 documentation guidelines for E/M services, and we believe reform should occur as rapidly as possible. We appreciate that CMS plans to offer physicians flexibility and choices in how to document E/M services. The AAFP supports CMS’ plan to allow physicians to choose, as an alternative to the current documentation framework specified under the 1995 or 1997 guidelines, either MDM or time as a basis to determine the appropriate level of E/M visit.

Pending the work of the CPT Editorial Panel in 2019, we believe CMS should implement this plan in 2020 and without regard to its planned single payment amount for levels 2-4 of the office/outpatient visit codes. We believe providing physicians with a choice about the basis for documenting E/M visits will facilitate E/M documentation that better reflects the current practice of medicine, improve clinical workflows, and alleviate documentation burden. Family physicians' ability to avail themselves of these choices may depend on the ability of their electronic health records (EHRs) to accommodate alternative E/M documentation. EHR readiness in this regard is unclear. As stated early, the AAFP encourages CMS to fully divorce itself from using these documents for auditing and payment purposes since CMS has stated that the document that outlines E/M documentation guidelines is not owned or maintained by the agency.

For those physicians who choose to document E/M services solely based on MDM, we believe physicians should rely on MDM in whatever construct exists within CPT. We understand that the CPT Editorial Panel is considering potential changes in this regard. Whether the panel decides on changes or not, the 1995 and 1997 versions of the E/M documentation guidelines (which CMS and other payers use) will need revision, because they do not appropriately capture the different levels of MDM in the context of current medical practice. The table of risk is particularly outdated.

We recommend CMS work with the CPT Editorial Panel and other stakeholders to make specific changes to the E/M documentation guidelines, especially related to MDM, with the goal of developing a single set of E/M documentation guidelines that can be used by all physicians and payers. There are several sets of guidelines in existence, including the one in the CPT code book, and many payers use the different sets of guidelines that are in existence, sometimes with their own variations. These various guidelines reflect the historical work of multiple parties. **We think a single set of guidelines that appeared in CPT and is used by Medicare and other payers would be another significant step toward administrative simplification for family physicians and other frequent users of the E/M codes.** We stand ready to work with CMS, the CPT Editorial Panel, and others toward the goal of a single set of easy-to-use E/M documentation guidelines simpler than those in CPT. These new guidelines should be used by Medicare and all payers.

Concerning documentation based on time, we understand that, for MPFS payment purposes, if a physician chooses to document using time, CMS will require the physician to document the visit was medically reasonable and necessary and that the physician personally spent the current typical time for the CPT code reported (e.g., 15 minutes when reporting CPT code 99213). We support this plan and strongly urge CMS to implement it in 2020. This is the same approach now used when physicians code based on time because counseling and/or coordination of care dominate the encounter, and it is most consistent with current E/M coding conventions. Thus, it would pose minimal administrative burden for physicians to implement. Further, to the extent the use of prolonged E/M service codes is keyed to the typical time in other E/M code descriptors, this approach is most consistent with current conventions related to use of prolonged services codes.

We think CMS can and should further simplify the documentation requirements for E/M visits relative to the current framework. We encourage CMS to adopt additional documentation simplifications in 2020, regardless of what it subsequently does with payment levels among the office/outpatient E/M services.

If CMS proceeds with its plan to adopt a single-payment amount for office/outpatient E/M visit levels 2-4 in 2021, then we would support CMS' corollary proposal to apply a minimum

documentation standard where—for the purposes of MPFS payment for an office/outpatient E/M visit for levels 2-4—physicians would only need to meet documentation requirements currently associated with a level 2 visit. If CMS intends to pay the same amount for any level of office/outpatient visit among levels 2-4, it is only essential that physicians document at least a level 2 visit. In addition, documentation at level 2 seems appropriate under those circumstances, although physicians may still need to document at a higher level for patient care and medical-legal reasons. Also, unless other payers follow CMS' lead, greater documentation will be required for them, compounding administrative burden in relation to payer.

Payment Policy

We appreciate CMS' decision not to proceed with its proposal to collapse the payment rate for office/outpatient visits levels 2-5. We are grateful that CMS heeded the concerns of the AAFP and others in this regard. We agree with CMS that a two-year delay in implementation of any change to the payment rates for office/outpatient E/M codes will provide time for organized medicine to work through the CPT Editorial Panel and, as needed, the Relative Value Scale Update Committee, to make changes that may obviate the need for further action on CMS' part.

Upon analysis, the AAFP has determined that the proposed \$90 value for the collapsed 99212-99214 codes would result in a net-negative impact on family medicine and would further perpetuate the undervaluation of primary care. We cannot support this proposal as a stand-alone policy. However, the inclusion of the \$13 add-on payment alters our analysis and potentially our conclusions on your proposal. Should CMS effectively demonstrate the willingness and ability to provide a \$13 add-on payment to the proposed collapsed code and the 99215 code, independent of onerous documentation requirements, the AAFP would view such a proposal favorably and work with you to implement such a policy. We continue to recommend that the AAFP's proposal to add a 15% increase to the proposed collapsed code and 99215 code for billings submitted by primary care physicians is a more appropriate mechanism for achieving our shared goal of improving the value of primary care. We encourage CMS to further examine the benefits of targeting a 15% increase for billings submitted by primary care physicians versus a \$13 add-on for billings of primary care services. Additionally, it remains clear to the AAFP that the underlying value of primary care services needs to be increased via a re-examination of the E&M codes and their values. The AAFP will provide CMS recommendations on this matter early in 2019.

The AAFP supports payment changes that help family physicians and their practices deliver primary care that meets the needs of each Medicare beneficiary. As CMS has recognized, the current MPFS undervalues the services and care that primary care physicians provide—and we appreciate CMS re-examining payment levels for those services. Despite our strong support for re-evaluating the values of codes primarily used for primary care services, we continue to disagree with CMS that the alternative of combining E/M visit levels 2-4, and maintaining level 5 coding and payment, is preferable to the current five separate payment levels, especially with the current effort by CPT and RUC to revise the descriptors and instructions for these codes with the intent to ease the burden of coding and documentation.

The planned payment levels still create at least two potential negative consequences for patients. First, Medicare beneficiaries will pay more out of pocket for level 2 and 3 visits than they have in the past, because the allowed amount on which their co-insurance is based will increase. Patient cost sharing will be the same regardless of the length or content of the visit. Second, the planned payment structure will penalize physicians who continue to address multiple problems at a given encounter, rather than ask patients to return for additional visits. This disruption in continuity and comprehensiveness is the foundation of our concerns. It is our

fear that the payment policy, if implemented in 2021, will work contrary to comprehensive, continuous, and coordinated primary care. We fear that it will incentivize more frequent visits that are shorter in duration and limited in scope. This result would be bad for beneficiaries and is inconsistent with high-performing, efficient primary care.

In short, we worry that CMS' plan could place an even greater emphasis on episodic care of discrete conditions that creates pressure to stint on care at an office/outpatient visit and churn patients. This scenario is contrary to the tenets of family medicine, which emphasize continuous, comprehensive care of patients.

More levels also create a greater need for program integrity mechanisms to prevent upcoding than what CMS' plan would require. However, this plan is not just about simplifying program integrity. It is also about reducing burden for physicians in a way that is sustainable for their practices and less onerous to their complex and high-need beneficiaries. The AAFP welcomes the opportunity to work with CMS, the CPT Editorial Panel, and others over the next two years to simplify E/M coding and documentation to achieve the goals of better outcomes for patients, reduced health care costs for CMS and patients, and lower administrative burden for both CMS and physicians. We suggest that CMS should implement a limited scale demonstration project on any payment revision prior to national implementation.

We also caution that, to the extent other payers do not change their coding and documentation requirements, implementing CMS' plan could increase complexity and confusion. We would like to work toward effective changes that all payers will accept and utilize. We stand ready to work with CMS to further develop this proposal and strengthen beneficiary access to primary care.

Add-on Codes

Regarding the add-on codes CMS plans to implement in 2021, we very much thank CMS for deciding to value the code for primary care services at a level equal to the code for non-procedural specialty visits rather than valuing primary care less. The opportunity to add the primary care code to nearly every level 2-4 visit in family medicine would approximate the 15% boost in primary care payment we advocated for in response to the proposed rule, at least for established patients. **We encourage CMS to extend this add-on code to include level 5 as well as levels 2-4, since the work inherent in primary care office/outpatient visits is not unique to levels 2-4.**

The AAFP agrees the planned value for the single payment rate for the E/M levels 2-4 new and established patient visit codes does not reflect the additional resources inherent to primary care visits. We appreciate CMS' attempt to address this in their single-payment rate plan by also creating an add-on code for primary care services. However, we continue to have some questions about the approach to this add-on code.

First, while we commend CMS for valuing the primary care add-on at a level equal to that of the other add-on for non-procedural specialties, we remain unclear how CMS arrived at that value. We believe additional information would be helpful to understand how CMS cross walked the value of both codes to 75% of the work and time for CPT code 90785 (interactive complexity). We understand why an existing add-on code for interactive complexity might serve as a useful reference code for a new add-on code intended to compensate physicians for visit complexity. What is unclear is why CMS thinks each of these add-on codes is worth only 75% of the value of that code.

We continue to believe CMS should eliminate the primary care add-on code and replace it with a 15% increase in payment for E/M services provided by physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics. In the final rule, CMS states:

“We also believe that in almost all cases where physicians and other professionals are furnishing primary care, information already in the medical record or on the claim, such as physician specialty, diagnosis codes, other service codes billed (chronic care or transitional care management services), or patient relationship codes would serve as sufficient documentation that the furnished visit met the primary care description. For example, we would expect that most practitioners enrolled in such specialties as family medicine, internal medicine, pediatrics, and geriatrics would be billing the primary care visit complexity add-on with every office/outpatient E/M visit.”

Given these statements, we strongly believe it would be simpler and equally effective to increase payment by 15% for E/M services provided by physicians who list their primary specialty designation as family medicine, internal medicine, pediatrics, or geriatrics.

Second, we remain concerned that the primary care add-on is available to physicians practicing in a non-primary care specialty. The statements from the final rule quoted above do not specify what combination of physician specialty, diagnosis, other service codes billed, and/or patient relationship codes would allow CMS to distinguish when the primary care add-on code is used appropriately outside of the specific examples of family medicine, internal medicine, pediatrics, and geriatrics. We harbor concerns that CMS will not be able to distinguish when the add-on code is being used appropriately and that any physician specialty will be able to report the primary care add-on code under almost any circumstance for an established patient outside the global period of a procedure.

Our opinion is that the application of the primary care add-on code, if implemented, should be limited to those physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. A primary care physician is a specialist in family medicine, internal medicine, or pediatrics who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the comprehensive care to the patient. Such a physician must be specifically trained to provide comprehensive primary care services through residency or fellowship training in acute and chronic care settings.

Physicians who are not trained in the primary care specialties of family medicine, general internal medicine, or general pediatrics, at times, may provide some primary care ‘services’ that are similar to those usually delivered by primary care physicians—but this does not constitute primary care. These physicians may focus on specific patient care needs related to prevention, health maintenance, acute care, chronic care, or rehabilitation. These physicians, however, do not offer these services within the context of comprehensive, first contact, and continuing care.

With this concern in mind, we recommend CMS redefine code GPC1X if it proceeds with its plan to implement it in 2021. Specifically, we recommend CMS redefine the code as follows:

Visit complexity inherent to evaluation and management associated with primary medical care services provided by family physicians, general internists, and general pediatricians, as well as other qualified health care professionals that work with them, who offer comprehensive first contact and/or continuing care for the undifferentiated patient not limited by problem origin, organ system, or diagnosis, and who serve as the continuing focal point for all needed health care services (add-on code, list separately in addition to a new or established patient evaluation and management visit).

The code could be used by any physician in one of the designated primary care specialties with any new or established patient E/M service. The code would not be applicable to any separately identifiable E/M service furnished within the global period of a procedure.

Regarding the planned add-on code for visit complexity in non-procedural specialties, we understand that use of the code is not limited to those specialties named in the descriptor. However, it is unclear how CMS will determine when the code is used appropriately. In the final rule, CMS states appropriate reporting of this code should be apparent “based on the nature of the clinical issues addressed at the E/M visit, and not limited by the practitioner’s specialty.” CMS goes on to state, “we note that information usually included in medical documentation, combined with diagnosis coding, would likely suffice for purposes of documentation.” CMS is unclear what this information is, and we imagine our non-procedural colleagues are also confused.

Third and last, regarding the add-on code for extended time spent with a patient during a level 2-4 office/outpatient E/M service, we note that the CPT Editorial Panel will consider a code change application for such a code at its February 2019 meeting. We encourage CMS to work with the CPT Editorial Panel to ensure that any CPT code(s) adopted in this regard meets CMS’ needs and otherwise obviates the need to establish separate Healthcare Common Procedure Coding System (HCPCS) code(s) for this purpose.

To be clear, we view CMS’ planned add-on codes as an attempt to address the deficiencies in CPT coding for E/M services related to current medical practice and longstanding concerns about the impact on payment for primary care and other services under the MPFS more generally. The codes are a step in the right direction, but do not achieve the desired ends. We are committed to working with CMS to find a better way forward that addresses E/M coding issues and appropriate payment for primary care. **Since it has been over a decade since the relative value of E/M codes was assessed and the codes were revalued, we call on CMS to take this opportunity to revalue the E/M codes relative to other services in the Medicare physician fee schedule as quickly as possible. This should be done and appropriate adjustments to E/M RVUs made in addition to the use of a primary care add-on code and/or the 15% increase in payment for such E/M services we are suggesting as an alternative to the add-on code. The AAFP would very much look forward to working with CMS on this process of re-valuing the office visit E/M codes.**

Other Issues

We sincerely thank CMS for not finalizing its proposal to apply a Multiple Procedure Payment Reduction (MPPR) policy to office/outpatient E/M services done at the same encounter as other services. We believe patients and primary care physicians will benefit from this decision.

Since CMS is not finalizing several elements of its proposals—especially the MPPR relating to global services billed with same day E/M services—the overall number of relative value units (RVUs) allocated to office/outpatient services would be increased relative to other services. Under CMS’ established methodology and consistent with the governing statute, CMS usually applies a budget-neutrality adjustment in the conversion factor to account for the changes in overall RVUs. This adjustment would apply to all physician fee schedule services, and CMS is not finalizing any deviation from that approach for 2021. However, CMS notes that, in some cases, it has proposed and finalized inputs for services that are designed to maintain the overall RVUs for those services despite changes in coding. **CMS also notes that while its standard practice has been to avoid scaling the full set of work RVUs to maintain budget neutrality, however the AAFP urges CMS to consider that alternative given the significance of office/outpatient visit codes in MPFS relativity.** CMS would address these alternative approaches through future rulemaking, if it were to consider either one for 2021.

As CMS considers how to make the changes in payments to office/outpatient E/M services, we encourage the agency to seriously contemplate the option of adjusting, or scaling, the work RVUs of all other codes within the fee schedule, rather than the usual process of achieving budget neutrality by adjusting the conversion factor. CMS must do so and revalue current E/M payment levels to reflect the lack of adjustments for over a decade. As CMS notes, the significance of office/outpatient visit codes in MPFS relativity is such that considering options to the usual process is warranted. Further, a rescaling of the rest of the fee schedule avoids taking away the conversion factor that CMS is otherwise giving with its planned payment for office/outpatient services and new add-on codes. Lastly, a rescaling of the rest of the fee schedule would be another step toward addressing the long-standing undervaluation of E/M services in general.

Again, the AAFP appreciates that CMS has shown a strong commitment to supporting primary care in recent years—and we look forward to working with CMS to further address this inequity. We appreciate that CMS recognizes problems within the current E/M documentation guidelines and codes, and we sincerely thank CMS for its desire and intent to address them.

III.A Clinical Laboratory Fee Schedule (CLFS)

Summary

CMS is expanding the pool of applicable laboratories to capture more hospital outreach laboratories and laboratories with significant Medicare Advantage patient populations.

AAFP Response

Since passage of the PAMA, the AAFP has repeatedly expressed concern to CMS about PAMA’s Section 216, which significantly revises the Medicare payment methodology for certain clinical diagnostic laboratory tests paid under the CLFS. The AAFP appreciates CMS’ recognition that the largest laboratories with the highest test volumes will continue to dominate the weighted median of private payer rates. Unfortunately, those rates do not cover the cost of appropriate point of care testing in the medical office when the patient is present with the physician – an important primary care service that improves patient convenience and outcomes of care. The 2018 CLFS has significant cuts that some tests are not fully covered, and the situation will continue to get worse when the next reduction in CLFS is implemented in 2019.

We strongly urge CMS to collect data from a representative sample of all laboratory sizes, including small and rural physician-owned laboratories to assure the continuation of this important point of care testing for Medicare patients in the primary care setting. Doing so would more accurately account for the cost of providing services paid under the CLFS. Furthermore,

we call on CMS to work with Congress to address inadequate and decreasing Medicare payments to in-office laboratories.

D. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Summary

CMS continues to develop the appropriate use criteria (AUC) program. CMS invited comments on methodology for the identification of outlier ordering professionals who would eventually be subject to a prior authorization process when ordering advanced diagnostic imaging services. CMS intends to evaluate claims data to inform the outlier methodology more fully in CY 2022 or 2023 rulemaking.

AAFP Response

The AAFP continues to have ongoing, significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements.

The AAFP strongly urges a delay in implementing this program until the AUC is fully aligned with the Quality Payment Program (QPP). 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. **We strongly urge CMS to exempt all primary care physicians participating in the QPP from AUC requirements.**

I. CY 2019 Updates to the Quality Payment Program (includes the extreme and uncontrollable circumstances MIPS eligible clinicians faced as a result of widespread catastrophic events affecting a region or locale in CY 2017 IFC policies)

The AAFP is very pleased with CMS for offering eligible clinicians (ECs) that exceed one or two of the low-volume threshold criteria the option to opt in to MIPS. We also appreciate CMS' use of the flexibilities authorized under the Bipartisan Budget Act (BBA) to continue a gradual implementation of the QPP. This includes the gradual increase in cost category weight and the gradual increase of the performance threshold. We encourage CMS to continue this gradual transition and to offer as much program stability as possible.

Promoting Interoperability

The AAFP appreciates CMS' desire to simplify the promoting interoperability category but remains extremely concerned and adamantly opposed to the "all or nothing" nature of the category. CMS believes the category is not "all or nothing," as an EC can submit a numerator as low as one. However, failure to report one measure results in a category score of zero. For all intents and purposes, this is an "all or nothing" structure.

CMS should eliminate health IT utilization measures or remove any required measures and provide ECs the flexibility to select measures relevant to their practice. All measures within the promoting interoperability category should be attestation based.

In addition, CMS has made reporting to a public health or clinical data registry a required measure. We are very concerned this may disadvantage small and independent practices, given the narrow exclusions available for these measures. For example, there are no exclusions available for a practice that is unable to connect to a registry because of the high costs. In this instance, the EC would be forced to attest "no" to this measure and would not receive any points in the promoting interoperability category. There are a limited number of registries available and applicable to family medicine. By requiring ECs to report this measure, CMS is essentially driving business to a small number of registries and numerous EHR vendors without any benefit

to the patient or practice. We urge CMS to reconsider use of this measure in future program years.

Performance measurement across categories

The AAFP encourages CMS to operationalize ways for ECs to report a measure/activity once and receive credit in multiple categories. There are already several measures and activities that span more than one category. Practices that report a quality measure that has a corresponding improvement activity should only need to report the quality measure and receive automatic credit in the improvement activities category. Similarly, attesting to an improvement activity that corresponds to a promoting interoperability objective or measure should yield automatic credit in the promoting interoperability category.

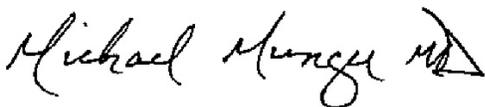
For example, a practice that reports, “Quality ID 371: Depression utilization of the PHQ-9 tool,” should automatically receive credit for the improvement activity, “IA_AHE_3: Promote use of patient-reported outcome tools.” This improvement activity specifically refers to use of the PHQ-9 tool. Requiring reporting to both categories is duplicative and unnecessarily burdensome. Or, a practice that attests to the improvement activity, “IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop,” should automatically receive full credit for both measures within the Health Information Exchange (HIE) objective. Again, the intent of this activity is nearly identical to the measures in the promoting interoperability objective.

In addition, the AAFP believes all practices that attest to being a recognized or certified patient-centered medical home (PCMH) should automatically receive full credit in the promoting interoperability category in addition to the improvement activities category.

Requiring ECs to report nearly identical measures or activities across multiple categories is redundant and increases administrative burden. We believe an updated architecture where ECs can report once and receive credit in multiple categories could alleviate significant burden from practices and allow them to more easily focus their efforts on relevant initiatives.

We appreciate the opportunity to comment. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,



Michael L. Munger, MD, FAFAP
Board Chair

About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine’s cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient’s integrated care team. More Americans depend on family physicians than on any other medical specialty.