



August 7, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the [request for information](#) (RFI) titled, “Reducing Administrative Burden to Put Patients over Paperwork” as published by the Centers for Medicare & Medicaid Services (CMS) in the June 11, 2019, *Federal Register*.

Family physician practices continue to be deeply overburdened by administrative functions at the point of care and after patient care hours. We appreciate the agency’s continued focus on this important issue and for the provisions included in the 2020 Medicare physician fee schedule. Further, the volume of administrative and regulatory functions required of physicians continues to be compounded by the lack of harmonization in these functions across payers. The average family physician has contractual relationship with 7 or more payers. In fact, 38% have contractual relationships with more than 10 payers. The AAFP strongly encourages CMS to work more closely with private payers to address administrative burden across all public and private payers.

According to a 2019 AAFP member survey, the top priority for the AAFP is to reduce physicians’ administrative and regulatory burden. Fully 74% of respondents said the time spent on administrative tasks has increased in the past year. They cite the greatest administrative burdens as those associated with electronic health record (EHR) documentation, prior authorization for prescription drugs, and quality measure reporting.

The AAFP strongly supports the “Patients over Paperwork” initiative and looks forward to providing formal comments on the 2020 proposed Medicare physician fee schedule, in which CMS has made some helpful proposals to reduce administrative burden. That said, as the RFI implies, much more can and must be done to reduce administrative burdens borne by practicing family physicians, so they can devote more time to patient care. We appreciate this opportunity to continue the discussion on improving healthcare delivery while relieving the administrative burden of participating in Medicare programs. The AAFP and other organizations developed [joint principles](#) on reducing administrative burden in healthcare. We urge CMS to closely consult, adopt, and adhere to these principles.

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The AAFP offers the following feedback on the categories identified by CMS in this request for information.

Reporting and documentation requirements

The AAFP calls for CMS to collaborate with specialty societies, frontline clinicians, patients, and health information technology (IT) vendors in the development, refinement, testing, and implementation of measures with a focus on decreasing clinician burden and integrating the measurement of reporting on performance with quality improvement, care delivery, and clinical workflow. We urge CMS to implement the registry- and EHR-based clinical quality measures from the core measure sets developed by the Core Quality Measures Collaborative to ensure harmonization of measures across the industry. CMS should provide transparency for the methodology used to rate physicians based on quality measures as well as simplify and standardize quality measure feedback reports across all payers. Feedback must be delivered in near or real-time for clinicians to make changes to their practice and improve clinical care. CMS should prioritize development of measures that matter to patients. Additionally, the AAFP believes that it is time for CMS to initiate important research regarding performance measurement in primary care and the use of broader outcome measures of comprehensiveness and continuity rather than the traditional process measures in use today which may be more appropriate for our subspecialty colleagues.

Coding and documentation requirements for Medicare or Medicaid payment

The AAFP appreciates recently proposed documentation changes included in the 2020 proposed Medicare physician fee schedule. We call on CMS to ensure that current clinical documentation requirements are revised or simplified so that the clinical note within the medical record focuses on the essential, clinically relevant elements of the patient encounter. The essential elements from the clinician's note should be automatically captured (i.e. as part of EHR logging) within the EHR without the need for unnecessary and irrelevant documentation from the clinician – an example would be the act of reviewing a medication list or labs would not need to be then documented by the physician.

We encourage CMS to work with the AAFP to identify and, if possible, implement technical solutions that would obviate the need for physicians to annually re-code permanent conditions for purposes of hierarchical condition category (HCC) scoring.

Family physicians are understandably frustrated with having to annually re-code conditions that are permanent for purposes of HCC scoring. That frustration leads to burn-out. Our members have also suggested this issue might be amenable to artificial intelligence and machine learning that could distinguish between reversible and irreversible conditions and thus eliminate the need to report the latter each year.

We believe technical solutions to address the issue of annually re-coding permanent conditions for purposes of HCC scoring may be possible. Such solutions would begin with a list of chronic diseases and other conditions (e.g. limb amputation) that would persist from year to year. From there:

- CMS could upgrade its infrastructure to support persistent conditions by beneficiary,
- Electronic Health Records (EHRs) could make a summary using national standards (already required in 2015 Edition certified EHR technology) to aggregate the patient's persistent conditions,

- The EHR summary could be automatically sent on the first claim of the year for each beneficiary, and
- That summary could be made available via application program interface for CMS to pull as needed.

Prior authorization procedures

Prior authorization, particularly that related to prescription drugs, is consistently listed as a leading burdensome administrative task. We strongly urge CMS to carefully consult and adhere to the AAFP's prior authorization and step therapy [recommendations](#). We call for prior authorization to be standardized and universally electronic to promote efficiency and reduce administrative burdens. The manual, time-consuming processes currently used in prior authorization programs burden family physicians, divert valuable resources from direct patient care, and can inadvertently lead to negative patient outcomes by delaying the start or continuation of necessary treatment.

Family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe medications and order medical equipment without being subjected to prior authorizations. In the rare circumstances when a prior authorization is clinically relevant, the AAFP believes the prior authorization must be evidence-based, transparent, and administratively efficient to ensure timely access to promote ideal patient outcomes. Additionally, family physicians participating in financial risk-sharing agreements should be exempt from prior authorizations.

Generic medications should not require prior authorization. The AAFP further believes step therapy protocols used in prior authorization programs, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, delay access to treatment and hinder adherence. Therefore, the AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans.

Family physicians also experience prior authorization hassles requesting DME. These requests typically require the physician to fill out a paper form or submit specific data for approval, and each DME company has different data requirements for submission. Specifically, the AAFP calls on CMS to simplify the current Medicare rules surrounding prescription of diabetic supplies, so patients and physicians would benefit without compromising the integrity of the Medicare program. Family physicians simply want to be able to prescribe efficiently and effectively what their diabetic patients need to help manage their condition in a way that maintains their health. Unfortunately, the current Medicare rules surrounding prescription of diabetic supplies impede this goal and add no discernible value to the care of such patients. If the patient regularly uses quantities of supplies that exceed the utilization guidelines, new documentation to support these supply quantities must be obtained every six months. We understand that glucose testing and other diabetic supplies are an identified area of claims processing errors within the Medicare program and that physicians have a role to play in fraud prevention. However, the related requirements have become overly burdensome with little to no value added to the actual care of the diabetic patient. Ideally, it should be acceptable for a physician to write for "diabetic supplies," which would encompass syringes, needles, test strips, lancets, glucose testing machine, etc., with only a need to provide a diagnosis and an indication such a prescription is good for the patient's lifetime.

Furthermore, we request additional improvements for CMS to make for Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to implement in caring for patients with diabetes. Specifically, the AAFP recommends CMS clarify provider roles and the documentation required in the provision of therapeutic shoes for persons with diabetes. Slight changes in interpretation of the regulations governing the Therapeutic Shoe Program for Persons with Diabetes (TSD) would significantly reduce burdens for physicians and beneficiaries. There is increasing confusion and frustration resulting from the process by which Medicare's diabetic beneficiaries qualify for and obtain medically necessary therapeutic shoes. The AAFP takes issue with the current requirements imposed by the DME MACs that the certifying physician must "obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts . . ." The co-signing requirement detailed above impedes this goal and serves no purpose in furthering patient safety or improving care for patients. The AAFP recommends that CMS direct the DME MACs to eliminate the co-signing requirements outlined above as they make coverage determinations for therapeutic shoes for persons with diabetes. We believe this change will result in balanced improvements that clarify provider roles and remove confusion and regulatory inconsistencies in the provision of this medically necessary benefit, while still preserving the integrity of the checks and balances under the TSD.

Policies and requirements for rural providers, clinicians, and beneficiaries

The AAFP remains concerned that the current MIPS reporting requirements necessitate an expanded human and technological infrastructure that many practices cannot afford, including most small rural practices. In the AAFP's 2017 Value-based Payment Study, 70% of respondents indicated lack of staff time as a barrier to implementing value-based care, while 41% indicated the financial investment required for health IT is a barrier. Among practice owners, 74% cite lack of staff time, and 52% cite financial investment as barriers to implementing value-based care.

Further, CMS continues to change program requirements, which makes compliance a moving target. Rural practices do not have the resources to dedicate staff solely to MIPS reporting as their staff is primarily involved in patient care. To reduce reporting burden for all MIPS clinicians, CMS should provide scoring flexibility through multi-category credit. There should be a single set of performance measures across all payers that are universal, meet the highest standards of validity, reliability, feasibility, importance, and risk-adjustment. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs.

One of the more concerning portions of MIPS is the promoting interoperability (PI) category. CMS is hamstrung in PI since the agency is bound to Meaningful Use requirements by legislation, including both the *American Recovery and Reinvestment Act* and the *Affordable Care Act*. The AAFP calls on CMS to work with Congress to repeal Meaningful Use requirements and allow Health and Human Services to remove these requirements from the PI category. Congress and CMS should work together to improve the implementation of the PI category by removing legislative barriers that restrain and complicate the category. Congress should encourage CMS to simplify the scoring, remove health IT utilization measures and the "all or nothing" requirement, and hold health IT vendors accountable for interoperability before measuring physicians on EHR use.

EHRs continue to pose significant challenges for small and rural practices. With fewer resources available, some rural practices use less expensive EHRs that have limited capabilities, which can make interoperability significantly more difficult. Additionally, EHRs often lack adequate technical support or may charge for providing basic user support. CMS' mandate to implement 2015 Edition certified EHR technology requires additional financial investments and staff support further inflate the barriers to successful value-based payment participation for rural practices. The AAFP welcomes the opportunity to partner with the CMS as it considers ways to boost clinically meaningful health IT use among small practices.

Finally, CMS should pursue thoughtful and appropriate e-prescribing flexibility that balances the need for security and efficacy with the challenges inherent in the practice of rural medicine, which can be impacted by limited or inconsistent technological capabilities. There should be safe harbors for those prescribers that incur significant administrative burden and/or access issues to prescribing software.

Beneficiary enrollment and eligibility determination

Our members report difficulties and the cumbersome nature of determining beneficiaries' status related to eligibility, medications, Annual Wellness Visits (AWV), and one-time vaccinations. We encourage CMS to offer physicians real-time coverage information at the beginning of the appointment since such information impacts which labs, services, and medications are performed/ordered during the visit. This is particularly relevant for services like AWVs that can only be billed annually by one entity. This real-time information should be integrated into health IT, so it is available at the point of care. This requires private and public payers, pharmacy benefits managers, and health IT vendors, to accept the same technical standards for capture and exchange of real-time beneficiary data.

Building a foundation for significant burden reduction through technology

Health IT has a great promise to dramatically reduce administrative and cognitive burden on physicians and other members of the care team as well as improve the quality of care and reduce cost. Unfortunately, current health IT implementations struggle to fulfill that promise. This is in large part because we do not have nationally recognized, semantic clinical data models, which hampers developers in creating smarter health IT that could dramatically decrease administrative burden. These models could enable health IT systems (i.e. EHRs and payment systems) to send and receive not just data but meaning. This sharing of meaning is a higher level of interoperability than currently available and would allow receiving systems to accurately reason about the data rather than requiring a clinician to perform all the reasoning.

HHS should promote efforts to create and maintain a set of nationally recognized clinical data models. To achieve this, AAFP believes HHS should support the work of Logica Health (formerly HSPC/CIIC) and similar efforts. In addition to empowering the development of health IT that can reduce administrative burden, these models could enable distributed systems (including EHRs) to work in concert to support care coordination and team-based care planning.

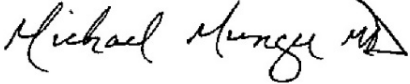
CMS processes for issuing regulations and policies

We call for CMS to provide financial, time, and quality-of-care impact statements for new and existing regulations and administrative tasks for public review and comment. Furthermore, we urge CMS to revise or remove entirely regulations or administrative tasks that negatively affect the ability to provide timely, appropriate, and high-value patient care.

Administrator Verma
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We appreciate the opportunity to comment and applaud your commitment to “Patients over Paperwork”. Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 rbennett@aafp.org with any questions.

Sincerely,

A handwritten signature in black ink that reads "Michael Munger MD". The signature is written in a cursive style with a distinct loop at the end of the "M" and a small flourish at the end of the "D".

Michael Munger, MD, FAAFP
Board Chair