



October 19, 2017

John R. Graham, Acting Assistant Secretary  
U.S. Department of Health and Human Services  
Office of the Assistant Secretary for Planning and Evaluation, Strategic Planning Team  
Attn: Strategic Plan Comments  
200 Independence Avenue SW., Room 415F  
Washington, DC 20201  
Submitted by email: [HHSPlan@hhs.gov](mailto:HHSPlan@hhs.gov)

Dear Acting Assistant Secretary Graham:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the [request for comments](#) on the [Draft Department Strategic Plan for FY 2018–2022](#) as published by the U.S. Department of Health and Human Services (HHS) in the September 27, 2017, *Federal Register*.

### About Family Medicine

Family physicians are dedicated to treating the whole person. These residency-trained, primary care specialists provide a wide variety of clinical services. They treat babies with ear infections, adolescents with hypertension, adults with depression, and seniors with multiple chronic illnesses. With a focus on prevention, primary care, and overall care coordination, they treat illnesses early and, when necessary, refer their patients to the right specialist and advocate for their care.

One out of every five office visits in the United States are made with family physicians. More than 192 million office visits are made to family physicians each year. This is 66 million more than the next largest medical specialty. More Americans depend on family physicians than on any other medical specialty. Family physicians are the main source of primary health care for the Medicare population. Approximately 94 percent of AAFP members participate in Medicare, and more than 81 percent of AAFP members accept new Medicare patients. More than 68 percent of AAFP members accept new Medicaid patients.

As the only medical specialty society devoted solely to primary care, the AAFP is engaged in virtually all health care issues, including coverage, cost and quality, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), physician payment and delivery system reform, health information technology, funding for family medicine training and primary care research, medical liability reform, and social determinants of health.

The AAFP appreciates that HHS both issued this strategic plan and requested stakeholder input. **We reviewed the draft and appreciate its appropriate emphasis on primary care physicians and their services.** We concur with Strategic Goal 1 in that it:

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- Emphasizes the need to leverage technology solutions to support safe, high-quality care and to advance interoperable clinical information flows, so physicians and other health care professionals can efficiently send, receive, and analyze data across settings.
- Promotes models that connect primary care with other sites of service, especially for dual Medicare-Medicaid eligibles.
- Discusses that HHS should pursue collaborative models for behavioral health integration with primary care that is team-driven, population-focused, measurement-guided, and evidence-based.
- Highlights the need to transform clinical training environments to develop a healthcare workforce that maximizes patient, family, and caregiver engagement and improves health outcomes for older adults by integrating geriatrics and primary care.
- Recognizes the need to reduce physician and provider shortages in underserved and rural communities by:
  - Supporting the training, recruitment, placement, and retention of primary care physicians through grants, student loan repayment, local recruitment, and other educational incentives.
  - Incentivizing physicians and providers to work in rural and other underserved areas.
  - Assisting primary care practices in integrating services for mental health and substance use disorders.
  - Supporting the development of telehealth models to increase access to care in rural and other underserved areas.

Regarding Strategic Goal 2, we support that the plan aims to:

- Improve access to high-quality care and treatment for mental health and substance use disorders
- Support the integration of the full continuum of behavioral health care and primary care and medical systems

However, it fails to acknowledge that only through advancing health equity can the HHS really improve health outcomes for all. The Academy and its membership recognize that increasingly, social risks are hampering family physicians' ability to provide effective clinical care to our patients. As such, the Academy has made addressing social determinants of health as they impact individuals, families and communities across the lifespan and [striving for health equity a strategic priority](#). For Strategic Goal 3, since family physicians also treat children, we fully concur with efforts to integrate trauma-informed, family-focused behavioral health services with pediatric primary care.

However, risk to optimal health outcomes for children can begin as early as preconception when the circumstances of where women live, work, learn and play can generate toxic levels of stress that are then passed along to the unborn in utero. The Academy urges HHS to adopt a life-course approach in its provision of health and social services to both men and women, which recognizes optimal health for children begins with healthy parents. Per the AAFP's position paper titled, "[Preconception Care](#)," we suggest that HHS, consider policies that:

- Provide access to comprehensive reproductive health care in the preconception and inter-conception periods and across the life-course.
- Minimize the risk from social determinants that increase poor maternal and child health outcomes
- Provide access to preconception interventions for women and men

Pertaining to Objective 3.4, the Academy recognizes the need to strengthen the workforce to provide high-quality and culturally competent care, however, increasing diversity in the workforce such that it reflects the populations it serves is necessary to reduce disparities among disadvantaged and vulnerable populations.

Per the AAFP's position paper titled, "[FAMILY PHYSICIAN WORKFORCE REFORM: Recommendations of the American Academy of Family Physicians](#)," we suggest that HHS, academia, and other stakeholders consider policies that:

- Review demographic changes in the U.S. population and adjust workforce projections accordingly.
- Discuss the impact of increased healthcare coverage on family physician demand, utilization, and access.
- Identify needed changes in healthcare financing and medical education funding to meet stated priorities

Pertaining to Strategic Goal 4, we agree with the HHS effort to invest in research to reduce the incidence of the leading causes of death. Like HHS, we support research to develop and test methods that increase primary care physicians' adoption of recommendations from the U.S. Preventive Services Task Force for clinical preventive services that address the leading and actual causes of death.

Objective 1.3 touches on the need to reduce administrative, regulatory, and operational burdens to expand coverage options in the Medicare Advantage and Part D Prescription Drug Programs, with which the AAFP fully agrees. **However, we believe that the final strategic plan must specifically address the need to reduce administrative, regulatory, and operational burdens for practicing physicians. Administrative simplification represents an industry-wide commitment to reducing health care costs by removing unnecessary burdens throughout the compliance, claims, and billing processes, and we encourage HHS to reflect this commitment within the final strategic plan.**

The AAFP is continuously working to alleviate demands placed on family physicians through entangling paperwork and needless regulatory complexities. Therefore, within the final plan, we strongly urge HHS to address the need to implement several administrative simplification suggestions, further detailed below, that would improve the flexibilities and efficiencies with the important programs administered by HHS agencies.

In reaction to President Trump's Executive Order on "Reducing Regulation and Controlling Regulatory Costs", the AAFP created an agenda for regulatory and administrative reforms to promote better primary care by preserving independent primary care practices. We call on HHS to significantly reduce the regulatory and administrative burdens on physician practices by acting on the following priorities:

- Prior Authorizations - The frequent phone calls, faxes, and forms physicians and their staffs must manage to obtain prior authorization (PA) for an item or service create enormous burden. PAs are becoming increasingly common as employers and insurance companies seek to control escalating pharmaceutical, radiological, and medical equipment costs. Since most family physician practices have contractual relationships with seven or more payers, they and their practices often navigate seven or more different prior authorization rules and forms. The AAFP believes PA must be justified in terms of financial recovery, cost of

administration, and workflow burden. The AAFP further believes rules and criteria for PA determination must be transparent and available to the prescribing physician. If a service or medication is denied, the reviewing entity should provide the physician with the criteria for denial. For medications, it should provide alternative choices to eliminate a guessing game. Additionally, PA for imaging services should be eliminated for providers with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship. The AAFP asks HHS and Congress to take action to eliminate the use of PAs in the Medicare program for generic drugs and durable medical equipment, create a single PA form that all Medicare Part C and D plans must use, and further limit or reduce the number of products and services requiring PAs. The AAFP suggests that HHS 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; 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.

- Chart Documentation - Documentation burdens have escalated dramatically without relief from adoption of electronic records. Indeed, current electronic record products have only added to that burden. Documentation for Advancing Care Information, PCMH recognition, CPC+, and other initiatives has reduced meaningful face time with patients. Additionally, documentation guidelines for E/M Services 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 reflected in Medicare's Quality Payment Program. The AAFP believes:
  - The primary purpose of medical record charting should be to document essential elements of the patient encounter and to communicate that information to other providers;
  - The use of templated data and checking boxes should be viewed as administrative work and not contributing to the care and wellbeing of the patient;
  - Changes should be made to the outdated E/M guidelines and the Medicare Program Integrity Manual. The changes should support medical information entered by any care team member related to a patient's visit. This standard should be applied by all Medicare contractors, Medicaid, marketplace policies, and private payers;
  - As part of the Medicare Quality Payment Program, the AAFP recommends that all documentation guidelines for E/M codes 99211-99215 and 99201-99205 be eliminated for primary care physicians.
- Medicare Certification and Documentation - Physicians want to efficiently order what their patients need to manage their disease conditions in a way that maintains their health. Unfortunately, the current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients. The AAFP believes:
  - The physician's order should be sufficient. Physicians should not have to sign multiple forms from various outside entities for patients to receive medically necessary physical therapy, home health, hospice, or Durable Medical Equipment (DME), including diabetic supplies;
  - Physicians should not be required to recertify DME supplies annually for patients with chronic conditions;
  - Authorization for supplies should be generic so that physicians are not required to fill out a new form every time a patient switches brands, including but not limited to diabetic supplies;

- Authorization forms should be universal across payers. Data within the forms should be standardized to allow for automated EHR extraction and population of forms;
  - Physicians should not be required to attest to the patient's status when the service is provided by another licensed health professional as is the case with diabetic footwear.
- 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 that integrates with the transformed practice environment. Furthermore, we call on HHS to place the burden of compliance on EHR vendors and not on physicians. EHR vendors, not the physicians who wrestle with inefficient and counterproductive EHRs in their practices, must be held accountable for the inadequate design and poor performance of their products.
- Interpretation Service Costs - Since 2000, physicians have been required to provide interpreters for Medicare and Medicaid patients with hearing impairments or limited English proficiency. 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 significant financial burden these regulations place on physician practices. 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 system. Medicare and Medicaid payment for essential primary care services are simply inadequate and interpretive services remain costly. In addition, if the patient reschedules or misses an 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 because family physicians provide a wide range of services. Because of the complexity of their practices, family physicians experience a more significant burden when multiple performance measures and quality improvement programs have no standardization or harmonization. The AAFP urges HHS to align quality measures as part of their overall approach to reducing administrative burden. To accomplish this, the AAFP recommends that HHS, 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.
- Inconsistent Claims Review - There are a multitude of post-claims review processes under Medicare alone: 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 HHS streamline programs and utilize one set of criteria that is universal.

- 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 - 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 HHS to delay the implementation of this program until the AUC is fully aligned with the MIPS 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.
- 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 combination with 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.
- Suggestions to Address the Opioid Abuse Disorder - Per the AAFP's [position paper](#) titled, "Chronic Pain Management and Opioid Misuse: A Public Health Concern," we suggest that HHS, other payers, and stakeholders consider policies that:
  - Adjust payment models to enable physicians to provide patient-centered, compassionate care in the treatment of chronic pain and opioid dependence and to appropriately compensate them for providing such care.
  - Expand government and private insurance coverage of medication-assisted treatment (MAT) in the primary care setting, with adequate payment for the increased time, staff, and regulatory commitments associated with MAT.
  - Expand the role of advanced practice nurses (APNs) and physician assistants (PAs) in providing MAT as part of a team supervised by a DATA 2000-waivered primary care physician.
  - In states that lack appropriate laws, advocate for better access to naloxone and appropriate Good Samaritan protections for prescribers and lay rescuers.
  - Work with state and federal licensing boards, the Drug Enforcement Administration (DEA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to destigmatize MAT, particularly in the setting of the community provider.
  - Work with state and national partners to improve the functionality, utility, and interoperability of prescription drug monitoring programs, and develop best practices for their use and implementation.

- Expand government and private support of research into the management of chronic pain, as well as methods to better identify and manage opioid misuse. Particular attention should be paid to vulnerable populations who are at higher risk for undertreatment of pain and/or for opioid misuse.

We appreciate the opportunity to provide these comments and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aafp.org](mailto:rbennett@aafp.org) with any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Meigs, Jr.', with 'MD' written in smaller letters at the end of the signature.

John Meigs, Jr., MD, FAFAP  
Board Chair

CC: Sarah Potter, HHS Strategic Planning Team Lead [[Sarah.Potter@HHS.GOV](mailto:Sarah.Potter@HHS.GOV)]