



September 5, 2018

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
Washington, DC 20510

The Honorable Kevin Brady
Chairman
House Committee on Ways and Means
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
Washington, DC 20515

The Honorable Greg Walden
Chairman
House Committee on Energy and Commerce
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
Washington, DC 20515

RE: Responsibilities of Government Health Payers Involving Shared Savings Payments

Dear Sens. Hatch and Wyden, and Reps. Brady, Neal, Walden, and Pallone:

On behalf of the American Academy of Family Physicians (AAFP), which represents over 131,400 family physicians and medical students across the country, I write to express the Academy's views on some of the challenges family physicians face in helping to effectuate Congress's intent in moving to value-based payment. As the committees who authored the Quality Payment Program—a monumental overhaul of the Medicare physician payment system—the AAFP believes that you may wish to be apprised of and oversee several concerns that the AAFP is working to improve, in order to achieve more reliable and accurate shared savings payments:

CMS Should Continue to Adjust Risk Adjustment Factor Scores Annually. CMS assigns risk scores (known as a risk adjustment factor or RAF) to each Medicare beneficiary. The RAF is based on demographic status, health conditions, and other factors. These RAF scores in turn are used to adjust payments to providers and physicians under some of the value-based models such as the Medicare Shared Savings Program. CMS currently updates the elements that drive the RAF three times per calendar year (prospective, end of lag, and final). The AAFP asks that the committees of jurisdiction continue to monitor and oversee this important process to ensure accuracy.

CMS Should Accept All Submitted Codes. The *Health Insurance Portability and Accountability Act* (HIPAA) standard requires insurers to accept up to 12 diagnosis codes for a claim. Family physicians are currently required to submit diagnosis codes under ICD-10-CM. The AAFP urges the committees of jurisdiction to ensure that under the Merit-Based Incentive Payment System (MIPS), CMS does not truncate codes.

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Category II CPT Codes on claims should be accepted as sufficient documentation to close gaps in care. Category II CPT codes are tracking codes for performance measurement that can ease administrative burden and help monitor performance on an ongoing basis—rather than once per year. CMS accepts Category II codes, as do most national payers. The AAFP asks that the committees of jurisdiction continue to monitor and oversee this important process.

Physicians Should Have 90 Days to Review and Correct Inaccurate Reports. The AAFP believes that the primary purpose of performance measurement and sharing of results should be to identify opportunities to improve patient care. To that end, reporting must be complete and accurate to be actionable. [AAFP policy](#) provides that “any physician reporting should provide a minimum of 90 days for physicians to review, validate, and appeal their payers’ performance report before public reporting.” While some payers provide such an opportunity, CMS provides only a 30-day review process for physicians in Medicare Part B. We urge the Committees to work with CMS to offer at least 90 days.

CMS Should Accept Supplemental Data in Value-Based Arrangements. Not all information that a physician needs to submit for value-based models can be done through CPT codes. In some instances, supplemental data (e.g. different pieces of the medical record) must be submitted to correct inaccurate reports or close gaps in care. Just as Medicare Advantage plans do, CMS must accept such supplemental data in order to accurately compute shared savings payments.

CMS Should Compensate Family Physicians for Activities Required to Satisfy Reporting Requirements. The advent of value-based payment has brought with it a raft of reporting requirements that consume valuable physician time and resources. Although the Medicare physician payment system does pay physicians for the practice expense bound up in specific service codes (e.g. physician office visits), it does not pay for the time or practice expense involved in fulfilling reporting requirements. Family physicians routinely spend 1-2 hours after clinic just on paperwork and entering information into the electronic medical record, which is uncompensated. The AAFP urges the committees to ensure that CMS fairly compensate family physician practices for their time and resources in helping to effectuate Congress’s intent in moving Medicare into value-based payment.

If you have any additional questions about the AAFP’s views, please do not hesitate to contact Andrew Adair, Government Relations Representative, at aadair@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Meigs, Jr.', with a stylized flourish and the initials 'MS' at the end.

John Meigs, Jr., MD, FFAFP
Board Chair