AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 24, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS–1631–FC)

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the final rule with comment period titled, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" as published in the November 16, 2015 *Federal Register*.

Target Recapture Amount

The AAFP appreciates and continues to support efforts by CMS to identify misvalued services and make appropriate adjustments in order to pay all physician services more accurately. However, we are extremely disappointed that the agency was unable or unwilling to identify the full 1.0 percent reduction in relative value units (RVUs) required in 2016 by the *Protecting Access to Medicare Act (PAMA)* of 2014, as modified by the *Achieving a Better Life Experience Act (ABLE)* of 2014. These laws stipulate that CMS must meet targets for net reductions in fee schedule expenditures associated with misvalued services for 2016, 2017, and 2018. The targets are 1.0 percent, 0.5 percent, and 0.5 percent, respectively. Failure to meet a given target requires a corresponding downward adjustment in the conversion factor. In the 2016 final rule, CMS was only able to identify 0.23 percent of the mandated 1.0 percent target for 2016. The AAFP considers the inability to identify enough overvalued codes in the fee schedule inconceivable. We recognize that Congress inadvisedly intervened and limited CMS's options in this regard by:

- Temporarily preventing the agency's ability to revalue 10- and 90-day global surgical codes as zero-day global services and
- Precluding any negative payment adjustment to radiation therapy and related imaging services for 2017 and 2018.

However, the AAFP still believes that the agency could have identified enough overvalued codes among the thousands of codes in the Medicare physician fee schedule to meet the 1.0 percent target for 2016. As it is, CMS is, in essence, saying that the codes comprising 99.77 percent of Medicare physician fee schedule payments are not overvalued. We do not believe that claim.

We trust that CMS is cognizant that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has a process in place to regularly identify and review potentially misvalued codes in the Medicare physician fee schedule and, therefore, that the agency is well aware of a list of codes that are potentially overvalued. Thus, the AAFP believes CMS should have taken the initiative to explore adjustments to the RVUs for these codes rather than reduce all physician payments by 0.77 percent due to *PAMA* and *ABLE* requirements.

Exacerbating this decision is the fact that physicians expected a 0.5-percent increase in the 2016 Medicare conversion factor due to the *Medicare Access and CHIP Reauthorization Act (MACRA)*. While the AAFP continues to support the *MACRA,* since it repealed the unsound Sustainable Growth Rate (SGR) formula, we are concerned that the target recapture amount called for by *PAMA* and *ABLE* creates a new and disconcerting policy to slash payments to Medicare physicians. Unlike the SGR formula, CMS actually has the authority and obligation to implement and appropriately mitigate the target recapture amount policy by reducing RVUs for overvalued services.

CMS made this situation even worse by excluding code-level input changes for 2015 interim final values from the calculation of the 2016 misvalued code target, since the changes occurred over multiple years and include years not applicable to the misvalued code target provision. This means that organized medicine does not get credit for any net decreases associated with those codes, because CMS chose to phase these adjustments in over multiple years. In essence, CMS is penalizing physicians even though the previous CMS process for handling RVU changes through interim final values is outside the control of physicians. The AAFP believes that CMS should have included 2015 interim final values in the calculation of the 2016 misvalued code target even though the change occurred over multiple years.

For a variety of reasons, payments to primary care services have repeatedly suffered under the Medicare physician fee schedule. Thus, when CMS applied the 2016 target recapture amount to all physician services, it made the disparity in primary care payment even more pronounced. Even if the agency was unwilling to reduce overvalued RVUs for 2016, at least the agency should have spared primary care services, especially evaluation and management codes, the annual wellness visit, transitional care management services, chronic care management services, and the new advance care planning codes. Although the target recapture amount affects all medical specialties, this has a particularly negative impact on primary care physicians, whose care and services have been consistently under-valued. We strongly advise the agency to prevent further reductions in payment for primary care services in 2016 and in future target recapture years.

Despite our disappointment in the final rule, the AAFP maintains support for the agency's authority to adjust physician codes in the spirit of more accurately paying for Medicare services. Though *MACRA* currently prohibits CMS from implementing AAFP-supported policies that would have transitioned all 10-day and 90-day global surgery packages to 0-day global periods, the AAFP urges CMS to quickly gather the information needed to accurately value surgical services from a representative sample of physicians. Despite Congressional meddling, the AAFP maintains a position that global surgical packages are inflated in terms of the number and level of post-operative visits assumed to be included and incorporated in the value of the codes in question. We also note that the current arrangement leads to unwarranted payment disparities in practice expense values between evaluation and management services in a global surgical package and stand-alone evaluation and management services. We note that who is providing these services is also an issue; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeon focuses only on the surgery itself. Under current Medicare payment rules, such visits would be paid at a discounted rate if reported separately by the NPs and PAs (assuming "incident to"

rules were not met); however, these visits are valued at the full physician rate in the global surgical package, even when the visits take place in a hospital (where "incident to" does not apply). We continue to believe that the current global surgical packages are incompatible with current practice and provide unreliable building blocks for new payment methodologies. The AAFP strongly urges CMS to continue efforts to pay accurately for surgical services.

Advance Care Planning

Though the target recapture amount policies disappoint and concern the AAFP, the 2016 final rule also contains welcomed new policy. We reiterate our full support for CMS efforts to establish coverage and payment for advance care planning services beginning in 2016. We maintain that published and peer-reviewed research shows that advance care planning services lead to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression, and lost productivity. We encourage CMS to prevent what could become inconsistent local interpretations by promptly beginning the process of making a national coverage determination for advance care planning services. The AAFP has already begun efforts to educate our members about these new services and encourage our members to offer them to Medicare beneficiaries.

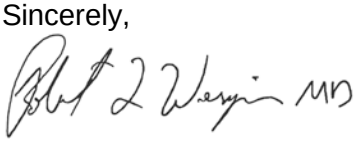
Annual Wellness Visit

Under the advance care planning subheading titled, "Who Can Furnish/Setting of Care," in one of the CMS responses, it states that advance care planning is primarily the responsibility of patients and physicians and that the agency expects the billing physician or non-physician provider to manage, participate, and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision. The AAFP wholeheartedly agrees with this response. The AAFP strongly recommends that this statement and policy should also be applicable to annual wellness visit services. In an April 30, 2015, letter from the American Academy of Family Physicians, and other physician organizations, we articulated our concern about the potential misuse of the annual wellness visit by commercial entities. The AAFP maintains that the annual wellness visit encourages Medicare beneficiaries to engage with their primary care physician or other usual source of care on an annual basis for prevention and early detection of illness, and we are still concerned that there are commercial entities that are subverting that benefit and may be misleading patients.

As with the advance care planning services, we urge CMS to specify that annual wellness visits are primarily the responsibility of patients and physicians and that the agency expects the billing physician or non-physician provider to manage, participate, and meaningfully contribute to the ongoing provision of services to the patient, in addition to providing a minimum of direct supervision. Such requirements for the annual wellness visit are consistent with the tenets of continuity of care, the process by which the patient and his or her physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care. Continuity of care is rooted in a long-term patient-physician partnership in which the physician knows the patient's history from experience and can integrate new information, such as that obtained from an annual wellness visit, and decisions from a whole-patient perspective.

We appreciate the opportunity to provide these comments. For any questions you might have, please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair