OREGON ACADEMY OF
FAMILY PHYSICIANS
MAKING HEALTH PRIMARY

September 7, 2018

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

Dear Administrator Verma:

On behalf of the Oregon Chapter of the American Academy of Family Physicians (OAFP), I write in response to the proposed rule titled, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program" published by the Centers for Medicare & Medicaid Services (CMS) in the July 27, 2018, Federal Register.

The OAFP commends your continued leadership and commitment to identifying and implementing policies that improve the Medicare program. We share your goals of reducing the administrative burden of modern medical practice and preserving independent physician practices. We are committed to assisting you and the Administration to achieve your stated goal of transforming the Medicare program into one that prioritizes the delivery of high-quality, patient-centered, and efficient care.

We respectfully offer commentary on four high-level items for your consideration. The four items are:

1. Alternative Payment Models for Primary Care
2. Priority Proposals in the 2019 Medicare Physician Fee Schedule
3. Impact on Medicare Beneficiaries
4. Impact on Solo and Small Physician Practices

Alternative Payment Models for Primary Care

It is our opinion that the reforms you have proposed in the 2019 rule, while laudable, will not achieve their intended goal as proposed. The complexity of implementing these changes in a fee-for-service environment would present major challenges to successful implementation. The regulatory framework of Medicare in general, and Part B specifically, make the implementation of the reforms proposed challenging, if not impossible, in our opinion.

It is important to note that most family physicians, especially those in independent practices, believe these proposed changes would have a net-negative impact on their practices. The feedback we have received has been appreciative of the concepts proposed but negative on the actual policies themselves.

It is our opinion that the pathway to true reform of the Medicare program, especially for primary care, lies in the broader proliferation of Alternative Payment Models (APMs) versus efforts to

tweak the legacy fee-for-service system. The authority granted to CMS and the Center for Medicare and Medicaid Innovation (CMMI) under previous laws provides you tremendous flexibility to implement changes in the delivery of care and payment of professional services.

To achieve meaningful transformation of primary care – and the health system more broadly – the American Academy of Family Physicians (AAFP) has developed and put forth the Advanced Primary Care Alternative Payment Model (APC-APM). The APC-APM proposal was considered and positively advanced by the PTAC in December 2017. Since that time, we have been actively engaged with CMMI to develop and implement an advanced primary care APM focused on small independent practices.

The APC-APM is consistent with the proposed changes put forth in the 2019 Medicare Physician Fee Schedule proposed rule – as well as the goals outlined in the April 2018 Direct Provider Contracting Request for Information to increase access, reduce administrative burden, and provide predictable revenue streams for providers to deliver patient-centered care. The APC-APM achieves both simplification in coding and documentation. It prioritizes comprehensive, continuous, and coordinated primary care, and it includes an evaluation of performance that is based in both quality and utilization. Additionally, while the APC-APM would require the use of an electronic health record system, the APC-APM would incentivize physicians to focus on using the EHR as a tool to assist them in care delivery, not as a tool focused solely on payment.

The OAFP strongly encourages you to seize upon the authority granted to you to identify and implement APMs, such as the APC-APM, as a means of achieving a greater investment in primary care, among other goals. The implementation of this primary care APM would drive Medicare toward the proven values of primary care: first contact, comprehensive, continuous, and coordinated care. Furthermore, it would be an important step towards achieving the Administration's goal of transforming the Medicare program into one that prioritizes the delivery of high-quality, patient-centered, and efficient care.

Priority Proposals in the 2019 Medicare Physician Fee Schedule

The 2019 Medicare Physician Fee Schedule seeks to improve the Medicare program by creating a practice environment that facilitates high-quality care delivered in the most efficient manner. In the rule, you have proposed four major changes to the Medicare Part B Fee-For-Service program that would have an immediate and measurable impact on family medicine. Those items are:

1. Simplify payment by adopting a single payment rate for evaluation and management (E/M) codes for new patients (99201-99205) and existing patients (99211-99215);
2. Reduce documentation burden by allowing physicians to document only at the 99202 or 99212 level;
3. Establish a new G-code valued at approximately $5.00 per visit that could be added to the newly established value for existing patient E/M services; and
4. Reduce by 50% payment for services provided in connection with an E/M code using the modifier -25.

In addition to these four items, the proposed rule outlines several other polices that aim to enhance patient care via telemedicine, coverage of other non-face-to-face services, and extended visits for complex patients. Each of these are important policies that we discuss in our comments below.

With respect to the 50 percent reduction in value for services provided at the same visit as an E/M service, using a modifier -25, the OAFP, along with the AAFP, has long-standing policy opposing such a policy or any other policy that seeks the reduction of payment for services provided to patients in connection to E/M services. We believe that the valuation of such services, as established through the RUC process, already accurately accounts for any efficiencies that may exist, and further reductions are not justified.

Finally, we also commend your efforts to create neutrality in payments between sites of care proposed in a separate rule. We strongly support site-neutral payment policies and encourage CMS to finalize that proposal.

The OAFP cannot support the proposed changes to E/M codes as proposed by CMS. As outlined in this letter, we believe the proposal would have a negative impact on family physicians in our state, especially those in small, independent practices. We recommend five major changes that would strengthen the proposed policies included in the 2019 MPFS. Those recommendations are:

1. Proceed with the proposed changes in documentation and implement these immediately – **but without the collapse to a single payment for codes 99202-99205 and 99212-99215**. Furthermore, we urge CMS to use its unique position to drive changes in documentation not only in Medicare, but through all public and private health plans.
2. Delay implementation of any changes to E/M policies or codes and their descriptors until the AAFP and other medical associations can work with CMS to develop new or revised office visit codes, descriptors, and values that incentivize comprehensive, continuous, and coordinated primary care and not fragmentation and churn.
3. Eliminate the proposed 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.
4. Eliminate the proposed 50 percent Multiple Procedure Payment Reduction (MPPR) for physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics.
5. Work with Congress to eliminate the applicability of deductible and co-insurance requirements for the chronic care management (CCM) codes. Eliminating CCM cost-sharing requirements would facilitate greater utilization of these codes and increase coordination of care for those beneficiaries with the greatest health care needs. Furthermore, we urge CMS to further reduce excessive CCM documentation requirements.

Impact on Medicare Beneficiaries

The OAFP is concerned that the changes included in the proposed rule may harm the quality and cost of care for Medicare beneficiaries. As noted previously, the value of primary care is achieved when delivery systems are foundational in first contact, comprehensive, continuous,

and coordinated primary care. To achieve these four principles, delivery and payment models must be aligned with these goals. We are concerned that the proposed changes would move us further from these principles by incentivizing greater fragmentation in care delivery. Since the proposed rule would place an emphasis on maximizing an allotted amount of time with a patient, versus comprehensiveness, it is likely that patients would experience more frequent, shorter duration physician visits. This incentivization of churn is inconsistent with the principles of advanced primary care and could not only be frustrating for patients but could also harm access to care in rural and other health professional shortage areas.

Additionally, since beneficiaries are required to pay 20 percent of most Part B services, it is possible that beneficiary out-of-pocket costs would increase due to more frequent physician or clinician visits. Also, visits paid at a higher rate than was the case before the proposed collapse of payment levels could multiply out-of-pocket costs. Many beneficiaries already face challenges accessing physicians due to logistical and financial challenges. We are very concerned that the proposed rule has the potential to create fragmentation and churn that could exacerbate these challenges.

Again, we believe the implementation of APM models such as the APC-APM, which focus on comprehensive, continuous, and coordinated primary care, are a better approach.

Impact on Solo and Small Physician Practices

Small, independent family medicine (primary care) practices are the foundation of our health care system, yet they face unique challenges that require some accommodation if they are to be successful in the future. The narrow margins of small, independent practices leave little room for variation in revenue. In addition, patient panels for these practices are more populated by Medicare and Medicaid beneficiaries and they tend to have fewer Medicare Advantage patients. These factors cause changes in Medicare fee-for-service to have a disproportionate impact on these practices.

Many small and independent practices have contacted our Chapter indicating the harm these changes would cause. They have outlined in detail the negative impact the proposed changes would have on them. The collapsing of E/M payment, in conjunction with the 50% reduction in payment for multiple services through the modifier -25, are perceived to be an economic death knell by these practices. Most have expressed that the implementation of the proposed changes would result in significant financial strains that would require either a decrease in the number of Medicare beneficiaries they care for or the sale of their practice to a larger organization. The further elimination of independent practices through consolidation is not positive for communities in our state, Medicare beneficiaries, or the financial sustainability of the Medicare program. The OAFP, like you, believes we need to protect these independent practices and take steps to ensure their economic viability.

Again, we believe the best way to protect these independent practices and preserve the important role they play in our health care system is to transition them away from fee-for-service towards APMs such as the APC-APM. The volatility fee-for-service causes is inconsistent with the comprehensive, continuous, coordinated primary care practiced by these family physicians.

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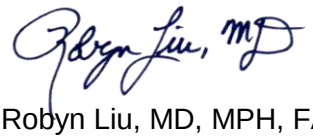
The OAFP stands ready to assist you in creating practice environments in our state that allow family physicians to continue performing at a high level.

In conclusion, the OAFP applauds your commitment to improving the Medicare program for beneficiaries and the physicians who care for them but asks that you carefully consider our concerns and suggested changes. We appreciate the opportunity to make these comments. Please contact Betsy Boyd-Flynn, Executive Director, at 503.528.0961 or bbf@oafp.org, with any questions or concerns.

Sincerely,



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