AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 8, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write to nominate Current Procedural Terminology (CPT) codes 99201 through 99215 (Office or Other Outpatient Services) as potentially mis-valued and request that CMS use its authority under section 1848(c) of the Social Security Act to review and revalue these codes. As explained in further detail below, the AAFP believes these codes are undervalued and that revaluation is critical to ensure the success of CMS efforts to move physicians into value-based, alternative payment models.

Changes in medical office practice that require review and revaluation

CMS last reviewed CPT codes 99201-99215 in 2006 as part of the third "five-year review" of the Medicare physician fee schedule. CMS consequently updated their relative values as part of the 2007 Medicare physician fee schedule. Apart from a slight adjustment in 2010 resulting from CMS's decision to no longer recognize the consultation codes, there has been no further review or revaluation in the intervening 12 years. Consequently, as the Medicare Payment Advisory Commission (MedPAC) has observed, ambulatory E/M codes like 99201-99215 have suffered passive devaluation as more and more procedural and other services have been added to the CPT code set and the budget-neutral Medicare physician fee schedule.[1]

We believe there is evidence to suggest that the work involved in these services has changed sufficiently in the past 12 years to warrant a new review and revaluation by CMS.

An even greater expectation that physicians will be proactive in diagnosing and treating illness

The preventive benefits available to Medicare beneficiaries has continued to expand since 2006. There are now at least 24 different covered preventive services available to Medicare

[1] Medicare Payment Advisory Commission. June 2018 Report to the Congress: Medicare and the Health Care Delivery System. P. 66. http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0 Accessed February 6, 2019.

beneficiaries.[2] With each new covered preventive service, there is a greater expectation on the part of patients that physicians will be proactive in disease prevention, health promotion, and the early diagnosis and treatment of disease. That expectation has implications for the physician work inherent in medical office practice, such as the documentation and scheduling of routine tests, the motivation of patients to undergo tests, and the follow up of results and patients who fail to make appointments for tests.

Proliferation and impact of electronic health records (EHRs) and related documentation

The proliferation of EHRs has increased work associated with office and other outpatient visits. The CDC estimates that, in 2015, 86.9% of office-based physicians were using any kind of EHR.[3] In 2007, the percentage was 34.8%.[4] In 2006, we estimate less than 20% of family physicians had EHRs in their office, where in 2018 that is 83%, based on our Member Census. Medication and problem lists must be accurately maintained by physicians. Furthermore, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

CMS has acknowledged the onerous burden placed on physicians by documentation requirements.[5] Through its Patients Over Paperwork initiative and changes made in the final rule on the 2019 Medicare physician fee schedule, CMS has attempted to lighten the burden on physicians to create duplicate sets of records. However, the burden remains, and the impact of increased documentation requirements on intra-service work and pre- and post-service time cannot be overestimated. In 2016, it was estimated that for every hour spent with patients, physicians spend 2 hours on EHR and desk work, according to an *Annals of Internal Medicine* study. Based on observation, 49% of physicians' office hours were spent on EHR and desk work while 27% was spent directly with patients. When meeting with patients, physicians spent 37% of their time on EHR and desk work. After office hours, physicians worked a mean of 1.5 hours per day, with most of that time dedicated to EHR tasks.[6]

Even more complexity of data to be evaluated and care to be managed

Evaluation and management of patients involves integrating even more information than it did in 2006, which increases the intra-service intensity of E/M services and add to the pre- and post-service time involved. This complexity of information is fueled by shared medical decision-making (discussed below), polypharmacy, and an ongoing explosion in the number of clinical guidelines that are good examples of what is considered optimal care. In 2006, the National Guideline Clearinghouse, created by the U.S. Agency for Healthcare Research and Quality

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[2] https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html Accessed February 6, 2019.

[3] https://www.cdc.gov/nchs/fastats/electronic-medical-records.htm Accessed January 10, 2019

[4] https://www.cdc.gov/nchs/data/nhsr/nhsr075.pdf#x2013;2012%20%5BPDF%20-%20347%20KB%5D%20 Accessed January 10, 2019

[5] https://www.cms.gov/newsroom/press-releases/cms-proposes-historic-changes-modernize-medicare-and-restore-doctor-patient-relationship Accessed February 6, 2019.

[6] https://www.jwatch.org/fw111995/2016/09/06/half-physician-time-spent-ehrs-and-paperwork Accessed January 10, 2019

(AHRQ) listed on its website over two thousand guidelines.[7] In 2012, there were 7,508 clinical practice guidelines, and thousands are produced annually, several hundred of which are relevant to family medicine.[8] Add to this all the new diagnostic and screening tests that have come into existence over the past 12 years, with their corresponding results to be considered, and it is no wonder that the complexity of care of even the most common conditions (e.g., diabetes) has increased.

Shared medical decision-making and social media

The paradigm of medical decision-making has continued to evolve into one "shared" by patients and physicians in a collaborative relationship, each with unique and important information components. Patients bring with them to this interaction not only information culled from the Internet and lay press (as they did in 2006) but also social media, which is more prevalent and more impactful than it was 12 years ago. One negative aspect is more misinformation available more readily to more people, with which physicians must cope as part of shared medical decision-making during office visits.[9] As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than 12 years ago.

A greater role for genomics in the evaluation and potential management of patients

With the mapping and sequencing of the human genome, medical professionals from essentially all specialties, including family medicine, have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is increasingly necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information has become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. [10] Indeed, some patients anticipate an ongoing role for their primary care physician after receiving genetic test results.[11] All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

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[7] https://onlinelibrary.wiley.com/doi/full/10.1111/j.1468-0009.2007.00505.x
Accessed January 10, 2019

[8] http://www.annfammed.org/content/12/3/202.full
Accessed January 10, 2019

[9] "Health Information on the Internet is Often Unreliable,"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1173379/
Accessed February 6, 2019

[10] Aronson, Samuel J. and Heidi L. Rehm. "Building the foundation for genomics in precision medicine." *Nature*. 2015 October 15; 526(7573): 336–342.

[11] Miller, Fiona A. et al. "The primary care physician role in cancer genetics: a qualitative study of patient experience." *Family Practice* 2010; 27:563–569.

Changes in the patient population

The patient population seen during office/outpatient visits has changed. We know the percent of the population that is overweight or obese has increased. The percentage of the population that is obese has trended upward since 2006, and between 2005- 2014, the prevalence of overall obesity and extreme obesity increased significantly among women.[12] As of 2015-2016, the percent of adults aged 20 and over with overweight, including obesity, was 71.6%. That's up from 66.7% in 2003-2006.[13] The patient population is getting older. In 2008, the percent of patients seen in the office who were 45 or older was 56.5%. In 2015, that percentage was 61.7%.[14] Chronic problems are an increasing reason of why patients present to the office. In 2008, chronic problems represented 35.9% of all office visits, and in 2015, they were 40.3%; the presence of at least one chronic condition at an office visit has increased from 53.8% in 2008 to 61%.[15] Other changes observed in the NAMCS data on office visits:

- Visits with mention of medication has increased from 74.4% to 76.2%
- Percentage of office visits involving two or more medications has increased from 53.6% to 58.3%

Social Determinants of Health (SDoH)

Academic literature is beginning to show how significantly social determinants affect the health and well-being of patients.[16] There is an assertion and increasing expectation that physicians need to know how to identify and address SDoH to be successful in promoting positive health outcomes for individuals and populations.[17] Activity at the federal level has increased in recent years. For instance, in response to new research, CMS is examining ways to account for social risk factors and reduce health disparities in its quality measurement programs.[18] This emphasis on SDoH did not exist the last time CMS reviewed and revalued codes 99201-99215.

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[12] https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity
Accessed January 10, 2019
[13] https://www.cdc.gov/nchs/fastats/obesity-overweight.htm
Accessed January 10, 2019
[14] National Ambulatory Medical Care Survey data. https://www.cdc.gov/nchs/ahcd/web_tables.htm
Accessed January 7, 2019
[15] National Ambulatory Medical Care Survey data. https://www.cdc.gov/nchs/ahcd/web_tables.htm
Accessed January 7, 2019
[16] American Academy of Family Physicians. "Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models. [Policy statement].
https://www.aafp.org/about/policies/all/socialdeterminants-paymentmodels.html Accessed February 6, 2019.
[17] American Academy of Family Physicians. Social determinants of health. [Policy statement].
https://www.aafp.org/about/policies/all/social-determinants.html. Accessed March 5, 2018.
[18] Centers for Medicare & Medicaid Services. CMS Quality Measure Development Plan: supporting the transition to the Quality Payment Program. Baltimore, Md.: Centers for Medicare & Medicaid Services; 2017.
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2017-CMS-MDP-Annual-Report.pdf. Accessed March 5, 2018.

The Opioid Epidemic

Unlike the last time CMS reviewed and revalued codes 99201-99215, the U.S. is facing an opioid epidemic in which primary care physicians play a crucial role.[19] This epidemic impacts office and outpatient visits in multiple ways. For instance, physicians must spend time to consult state prescription drug monitoring programs. They must counsel patients on alternative therapies for pain treatment and management. Opioids add to the complexity of poly-pharmacy, which impacts the medical decision making of office/outpatient E/M services.

Other calls for review and revaluation of E/M services

The AAFP is not alone in its call to review and revalue E/M services, especially 99201-99215. In chapter 3 of its June 2018 report to Congress, MedPAC discussed the need to rebalance Medicare's physician fee schedule toward ambulatory E/M services. MedPAC stated:

> Ambulatory evaluation and management (E&M) services . . .are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission is concerned that these services are underpriced in the fee schedule for physicians and other health professionals ("the fee schedule") relative to other services, such as procedures. This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E&M services.[20]

We share MedPAC's concern, and like MedPAC, we believe CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M services while reducing payment rates for other services (e.g., procedures, imaging, and tests). Under this approach, the increased payment rates would apply to ambulatory E/M services provided by all physicians, regardless of specialty.

The increases would not apply to the E/M component of global surgical services. As required by law, CMS is collecting data to validate the number and level of E/M services assumed to be included in global surgical services. The Office of Inspector General and others have questioned the accuracy of current assumptions underlying 10- and 90-day global codes. Until CMS can adequately address those questions, we believe it would be imprudent to adjust the E/M component because of any changes to the values of stand-alone office/outpatient visit codes 99201-99215.

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[19] American Academy of Family Physicians. "Authors See Crucial Role for Primary Care in Opioid Epidemic." *AAFP News*. July 10, 2018. https://www.aafp.org/news/health-of-the-public/20180710fpsopioids.html Accessed February 6, 2019.

[20] Medicare Payment Advisory Commission. June 2018 Report to the Congress: Medicare and the Health Care Delivery System. P. 65. http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0 Accessed February 6, 2019.

Why revaluation of CPT codes 99201-992015 is critical

As noted, there are potential issues with beneficiary access and physician supply attached to mis-valuation of E/M codes. Further, the benchmarks used to determine payments to Medicare Advantage plans are based on fee-for-service spending, which reflects fee schedule payment rates. Moreover, many commercial plans use relative value units from the Medicare physician fee schedule to determine their own payment rates for clinicians. Thus, mis-valuation of E/M services has a negative spill-over effect in Medicare Advantage and commercial physician payment.

However, we believe revaluation of CPT codes 99201-99215 is most critical for another reason. CMS desires to move physicians into value-based, advanced alternative payment models (AAPMs) that move payment for E/M services away from fee-for-service and toward other payment arrangements (e.g. per patient per month payments). An example of this effort is Track 2 of the Comprehensive Primary Care Plus (CPC+) initiative. However, as MedPAC observed in its June 2018 report, all AAPM models use fee-for-service payment rates as either the basis of payment or the reference price for setting the global or bundled payment amount. If the actuarial basis for E/M payment alternatives is the relative values currently assigned to E/M services under fee-for-service (as they are under CPC+), then the foundation of the corresponding AAPM is fundamentally flawed and won't support CMS's efforts. Thus, revaluation of codes 99201-99215 is critical to ensure that CMS succeeds in moving physicians into value-based, APMs. Like CMS, the AAFP desires to keep advancing APMs. Revaluation of codes 99201-99215 is a necessary step.

Final thoughts

We acknowledge the CPT Editorial Panel will consider a proposal at its February 2019 meeting that, if accepted, will require review and, potentially, revaluation of the codes in question. This request is not meant to derail that effort. However, we believe review and revaluation of codes 99201-99215 is necessary, even if the CPT Editorial Panel does not act or otherwise editorially revises the codes.

We understand the magnitude of what we are asking. As CMS noted in the final rule on the 2019 Medicare physician fee schedule, office/outpatient E/M visits comprise approximately 20% of allowed charges under the Medicare physician fee schedule and are furnished by nearly all specialties. We stand ready to assist CMS in the requested review and revaluation and will be an active participant in whatever mechanism CMS chooses to conduct that review and revaluation.

Thank you for your time and consideration of this request. If you or your staff has any questions about this matter, please contact Mr. Kent Moore, Senior Strategist for Physician Payment, at the AAFP at kmoore@aafp.org or (913) 906-6398.

Sincerely,

Michael L. Munger, MD, FAAFP
Board Chair

Cc: Geri Mondowney (CMS)

About Family Medicine
Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.