Reference Committee on Practice Enhancement

2017 Congress of Delegates of the American Academy of Family Physicians, San Antonio, TX - Alternate Delegate, Hilary Alvarez, MD

The Reference Committee on Practice Enhancement considered a variety of resolutions meant to improve practice conditions for family physicians.

Four resolutions were adopted.

The most popular (based on the amount of positive testimony) was substitute **Resolution 306** (Georgia), which emphasized the importance of Medicare Wellness Visits occurring in the patient's primary care setting, with an interesting suggestion to involve organizations such as AARP in encouraging this:

> RESOLVED, That the American Academy of Family Physicians educate public service agencies and other membership organizations with an established history of providing evidence-based consumer health information for individuals eligible for Medicare about the need for annual wellness visits to be done in the patient's primary care setting, and be it further.
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> RESOLVED, That the American Academy of Family Physicians encourage public service agencies and other membership organizations with an established history of providing evidence-based consumer health information for individuals eligible for Medicare to advocate for the central role of primary care in performing the annual wellness visits and support legislation and regulations that preferentially direct beneficiaries to their primary care physicians or physician designee for these exams.

The Congress also adopted a complicated substitute **Resolution 302** (Connecticut) regarding insurers and shared savings programs, requesting that the AAFP advocate for risk adjustment scores to be adjusted annually, that insurers accept CPT-2 codes as sufficient documentation, that providers be given enough time to validate data and reconciliation reports, and that providers receive fair compensation by payers to submit the supplemental data needed to correct inaccurate reports. The resolution also tasks the AAFP to advocate with Congress for legislation that mandates the above.

The third resolution adopted out of this reference committee was **Resolution 303**, a substitute resolution for a resolution brought by New Jersey, similar to one proposed last year.

> RESOLVED, That the American Academy of Family Physicians support seamless exchange of laboratory data between the laboratory and any member of the care

team, when requested. The data should be shared through the practice's usual preferred method of receiving results at no further cost to the practice.

Finally, substitute **Resolution 309** (Virginia) was adopted. It deals with simplification and standardization of documentation for DME, advocates that physician attestation (rather than clinical records) should be sufficient for medical necessity, and encourages development of an online database of accredited DME suppliers for each health plan.

Five of the ten resolutions were referred to the Board of Directors for further study.

Resolution 301 (Arizona) urged CMS to expand the types of licensed behavioral health providers that can be credentialed to provide services to Medicare beneficiaries, and to urge payers to include payment for licensed behavioral health providers as part of a patient's medical benefits when the services are delivered in a primary care office under a primary care physician's supervision.

Testimony was very favorable toward further integration of behavioral health into primary care but this was referred for further study given concerns about scope of practice and payment issues.

Resolution 304 (New Jersey) urged the AAFP not to endorse any proposed payment metric unless there is a concomitant elimination of an existing metric. This was referred since the AAFP is already deeply involved in a variety of efforts to reduce administrative burden, including by streamlining metrics.

A substitute **Resolution 308** (Indiana) regarding MACRA advocates for incremental pay increases for small practices that participate in QI activities outside of the formal Merit-based Incentive Payment System (MIPS) structure was referred to the board since this would be a change to MACRA.

Resolution 310 (Mississippi) urged CMS to allow PAs, as well as NPs, to perform face-to-face visits for hospice recertification with appropriate physician oversight or collaboration. All of the testimony was in favor, but given concerns about scope of practice, this was referred to the board to confirm that the specific language around scope avoids any confusion.

Resolution 311 (Mississippi) instructs the AAFP to lobby that 85% of all health care expenditures go only to direct hands-on patient care, that there be penalties for payers who require or create administrative burdens which require more than 15% of the health care dollar, and that CMS reduce the burden or increase provider payment for any administrative costs exceeding 15%. This was referred to the board given ongo-

ing work on the medical loss ratio and advocacy around health care spending for primary care in particular.

One resolution was not adopted:

Resolution 307 (Illinois) asked the AAFP to work with CMS and/or Medicaid to set up a pilot project to demonstrate the value of a direct primary care practice. This was not adopted since there would be a large fiscal impact to the AAFP. Instead, the AAFP staff will continue to communicate information about the DPC pilot programs already in process.

The full text of the committee report with actions taken can be found at:
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2017/PEwithActions.pdf