

TAFP MEMBER ASSEMBLY WITH COUNCIL FORUMS

Friday, April 10, 2026

6:30 – 8 p.m.

Kalahari Ballroom

Kalahari Resorts and Conventions in Round Rock, Texas

AGENDA

1. Call to order by Ike Okwuwa, MD, MBA, President
2. Welcome and introductions
3. TAFP Update – Ike Okwuwa, MD, MBA
4. Council updates
 - a. Council on Workforce and Member Engagement – Eric Lee, MD
 - i. Task Force on Physician Well-Being
 - ii. Task Force on IMG Licensure and other issues
 - b. Council on Medical Practice – Triwana Fisher-Wikoff, MD
 - c. Council on Health of the Public – Li-Yu Mitchell, MD
5. CPAN/PeriPAN – Nithya Mani, MD, Department of Psychiatry and Behavioral Sciences, Dell Medical School
6. AI Downcoding – Tina Philip, DO
7. Other business
8. Adjourn

2026 TAFP MEMBER ASSEMBLY

Friday, April 10, 2026, 6:30 – 8 p.m.

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 January 2026

The Task Force on IMG Licensure and other issues met on Monday, January 26, 2026, on Zoom to work on identification and explanation of the various factors that lead to IMGs who train at Texas residency programs to leave Texas for practice.

Looking at all family physicians trained at Texas Residency Programs from 2010 to 2024, the data shows:

- Almost 30% of residency grads for those years are International Medical School Graduates.
- Only 33.7% of IMGs from that time period are current TAFP members vs. 41.8% of US grads who completed residency in the same time period.
- A higher percentage of IMGs who trained in Texas are AAFP members in other states – 19.3% vs 16.6% of US grads
- 47% are not AAFP members. If a member doesn't renew, AAFP stops updating their contact information, so it is difficult to determine how many non-members are attributable to Texas.

There are two issues – obtaining a Texas medical license and, for some, securing a visa to continue living in the US. There are other states where those two things are easier and less expensive. **Our objective is to retain more family physicians in Texas to meet our workforce needs.**

Issue 1: Obtaining a license from the Texas Medical Board

Texas has a reputation for being one of the more expensive states for licensure and for longer processing time. That is true for US medical school graduates and international medical graduates. For IMG physicians it can be even more expensive and take longer. IMG physicians cannot apply for licensure in Texas until the end of their second year of residency. TMB is mandated to average application processing in 51 days, but the clock starts when the application is complete so if anything is missing or needs correcting, it can take longer.

If the resident attended a medical school that is already on the list of approved international schools, it is easier but still takes time. If the school is not on the list of pre-approved schools, it can be a lengthy process to obtain documentation from the school. There is a form that must be completed by the medical school related to their accreditation. The other option for physicians in this situation is to obtain a license in another state and use that to get their Texas license faster. Obviously, that adds to the expense and timeline.

According to a chart prepared by the Federation of State Medical Boards in 2024, initial licensure fees range from \$35 in Pennsylvania to more than \$1,100 in California and Rhode Island. Texas is on the high end at \$817. Some applicants use the Federation Credentials Verification Service - a universal application. That adds an additional expense.

Advocacy questions:

- How can we expand the list of pre-approved schools?
- When a physician ultimately obtains a license, is their medical school automatically added?
- Could there be a lower initial license fee for those completing residency in Texas to encourage more to stay and practice?
- What are the barriers to faster processing of applications seen in other states? Is that just funding for staff?
- Would TMA be interested in helping with this advocacy?

Issue 2: Immigration status

For IMG residents who are not US citizens, an added complication is obtaining a visa. We don't have any data on how many of our IMG residents are in this category. Of the 1,038 resident members in Texas right now, 291 are IMGs. They graduated from a total of 136 medical schools.

J-1 visa during training

Resident physicians obtain a J-1 visa through the Educational Commission on Foreign Medical Graduates (ECFMG) authorized by the U.S. State Department for the period of their training. To apply, the physician must have passed USMLE step 1 and step 2 CK (or equivalent), have a valid ECFMG certificate, have a contract or official letter of offer for a position at a residency program, and provide a statement of need from the Ministry of Health of the country of last legal permanent residence regardless of country citizenship.

What happens after training? J-1 visa waiver or return to home country

Upon completion of training in the U.S., J-1 visa holders must return to their home country for a period of two years before being eligible for a change or adjustment of visa status unless they obtain a waiver. Under the law, the following three circumstances can provide a waiver of the two-year residency requirement:

- The waiver applicant can demonstrate that he or she will suffer from persecution in his or her home country or country of last legal permanent residence.
- Fulfillment of the residency requirement would bring proven exceptional hardship to the applicant's spouse and/or children who are U.S. citizens or permanent residents.
- The applicant is sponsored by an Interested Governmental Agency (IGA) that is interested in the physician's continued employment in the United States.

The following governmental agencies have sponsored waivers for international medical graduates:

- The Department of Health and Human Services
- The Department of Veterans Affairs
- The Appalachian Regional Commission
- The Department of Agriculture
- The Department of Housing and Urban Development
- State departments of public health may sponsor up to 30 J-1 physicians per year for waivers to provide care in underserved communities.

Once an international medical graduate receives a J-1 waiver and a state medical license, he or she may obtain a new work authorized status for U.S. employment, which in most cases will be an H-1B visa.

Conrad 30 J-1 Visa Waiver Program

The only governmental agency with information readily available on their waiver program for physicians in Texas is the Department of State Health Services. There are attorney websites that mention other paths but it's not clear how a resident would secure a waiver without their assistance. According to the Texas Department of State Health Services website, the Conrad 30 J-1 Visa Waiver Program allows each state to recommend up to 30 IMGs each year for a waiver. The Conrad 30 program is specifically for physicians. To be eligible, the physician must agree to practice medicine full-time at a health care facility located in a federally designated Health Professional Shortage Area or Medically Underserved Area for a period of no less than three years.

In a large, populous state like Texas, 30 waivers will go faster than other states who may not use all their waivers. In Texas, the application should be submitted immediately when the application window opens on September 1 each year. They should apply during their third year of residency and must have an employment contract to practice in a facility located in a HPSA or MUA. Applicants can use an attorney to assist and that can add to the expense. The fee for the application is \$3,000. If DSHS does not recommend the waiver for the physician, the fee is refunded.

H1-B Visa

Applicants are notified of approval for the Conrad 30 waiver in March and can then obtain a new work authorized status, which in most cases will be an H-1B visa. They must be on salary within 60 days of the approval of the H-1B visa and the employer pays for the visa. Note that the timing is critical as the resident physician can't stay in the country past 30 days of the expiration of the J-1 visa they had during residency.

H1-B visa is approved for 3 years as long as the physician stays with the same employer. If the physician switches employers, they have to get a new visa. Renewal every three years includes

wage verification and takes around nine months. There is premium processing available to expedite the renewal, but it has additional fees.

Advocacy questions

- Could AAFP advocate to expand the number of waivers through the state department? Or to re-allocate based on the population of the state?
- Are there other pathways to obtain a waiver in Texas (besides the \$100k program)? Does TMA provide any guidance to members?
- Is there any data on how many physicians trained in Texas return to their country?

CPAN and PeriPAN supports family physicians and the families we serve

<https://www.tafp.org/news/CPAN-and-PeriPAN-supports-family-physicians>

By Ike Okwuwa, MD, TAFP President

March 03, 2026

Greeting colleagues. As family physicians, we care for patients and families through every stage of life. We are often the first to identify mental health concerns. Access networks increase identification of mental and behavioral health conditions by more than 40%, according to a 2023 study in “Clinical Pediatrics,” underscoring the value of timely, expert support in family medicine.

That is why the TAFP Board of Directors voted in January to strongly endorse the Child Psychiatry Access Network (CPAN) and the Perinatal Psychiatry Access Network (PeriPAN) as trusted clinical resources for family medicine practices.

CPAN and PeriPAN provide real-time access to mental health experts, including child, adolescent, and reproductive psychiatry. These programs are designed to support family physicians through:

- real-time peer-to-peer phone consultation;
- vetted, personalized referrals and resources;
- one-time direct psychiatric consultations so your patients don’t wait; and
- free high-yield CME offerings.

CPAN supports mental health care for children and adolescents, while PeriPAN provides expertise for the mental health care of pregnant and postpartum women.

Importantly, this access model works. Research published in “Clinical Pediatrics” in 2023 found a 43% increase in the identification of mental and behavioral health conditions after clinicians enrolled in the Wisconsin Child Psychiatry Consultation Program — a model similar to CPAN. These findings underscore how access networks like CPAN and PeriPAN strengthen family physicians’ ability to recognize and address mental health needs earlier and more effectively.

How CPAN and PeriPAN work

- Call (888) 907-2726 with a question or concern.
- A trained mental health expert answers immediately (Monday – Friday, 8 a.m. – 5 p.m. CT).
- If needed, a psychiatrist will call back within 30 minutes or at a time that works for you.

These programs reflect the central role family physicians play in identifying and coordinating mental health care. By using CPAN and PeriPAN, we can address concerns earlier and improve outcomes for patients and families across Texas.

No question is too small, and I encourage you to use these resources as often as needed.

You can stay up to date with CPAN and PeriPAN program features, free CME opportunities, and additional resources on [Facebook](#) and [LinkedIn](#).

Why Improving Access to Mental Health Care is an Ethical Imperative

Nithya Mani, MD
Medical Director, Texas Child Mental Health Care Consortium
Director of Pediatric Public Psychiatry
University of Texas at Austin

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This program is provided through the Texas Child Mental Health Care Consortium

<https://tcmhcc.utsystem.edu>

The presenter has no disclosures

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Presentation Goals

1. Review incidence of mental health disorders in youth and peripartum women
2. Summarize outcomes for untreated mental health disorders
3. Describe Access Programs within the Ethical Construct of Beneficence, Nonmaleficence, Justice
4. Describe Texas' CPAN and PeriPAN Access Projects
5. Identify barriers to mental health assessment and treatment in your clinical setting
6. Develop plans for CPAN and PeriPAN utilization to improve patient care within your practice

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Goal 1: Review Incidence of Mental Health Disorders in Youth and Peripartum Women

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Rates of Common Mental Health Disorders

Youth	Peripartum Women
<ul style="list-style-type: none"> • 1 in 3 teens ages 13-18 has an anxiety disorder, this is closer to 40% for teenage girls • Less than 50% of young people reporting depressive symptoms receive treatment • The isolation caused by the COVID-19 Pandemic worsened mental health distress for youth & parents • Suicide is the 2nd leading cause of death for youth starting at 10 years of age 	<ul style="list-style-type: none"> • 1 in 5 peripartum women suffer with a Maternal Mental Health Condition (MMHC) • Less than 15% receive professional help • Women in marginalized communities have even higher rates of peripartum MMHCs and less access to care • Overdose & suicide combined are the leading causes of death for women in the 1st year postpartum


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Primary care clinicians and obstetric clinicians can expect that a significant number of their patients have or have experienced mental health distress

Referring out this number of patients means they are often sitting on a wait list getting no care at all

Even if there is no wait list, a significant number of patients do not attend mental health appointments due to time commitment and stigma


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Goal 2: Summarize Outcomes for Untreated Mental Health Disorders


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Outcomes When Mental Health Disorders are Not Addressed




Youth

- Increase in mental health emergency room visits
- Hospitalizations for children related to mental health increased by 26% between 2009 and 2019
- Increase in substance use
- Increase in school refusal and drop out
- Increase in suicide




Peripartum Women

- Increased smoking and substance use during pregnancy and postpartum
- Preterm delivery, low birth weight, increased NICU admission
- Lactation challenges, bonding issues
- Untreated MMHCs have multigenerational consequences: cognitive delays, motor & growth issues, behavioral problems & mental health distress in offspring
- Untreated MMHCs cost Texas about \$2.2B a year when looking at costs associated from conception to 5 years postpartum



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The outcomes of untreated mental health distress in peripartum women and youth are devastating

This is a public health crisis we must all work together to address

It is an ethical imperative that we help identify those who are suffering and provide them care that helps them achieve wellness

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Goal 3: Describe Access Programs Within the Ethical Construct of Beneficence, Nonmaleficence, Justice


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History of Access Projects to Improve Collaborative Care

Massachusetts Child Psychiatry Access Project (MCPAP) started the very first Access Project in the United States in 2004 to support clinicians caring for youth in MA


Due to the success of MCPAP, the program was expanded to support clinicians treating pregnant and postpartum women (MCPAP for Moms) in 2012

Building on the evidence and the experience of MCPAP and MCPAP for Moms Access Projects were launched by states all over the country funded by both state and federal dollars




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Outcomes When Collaborative Care Access Project Models are Implemented




Youth

- High rates of parent satisfaction with PCPs who utilize the service
- Further strengthened PCP relationship with families
- Enhanced ability to deliver mental health care consistent with family preferences
- PCP applied knowledge gained in previous calls to subsequent patients




Peripartum Women

- Feasible, acceptable, and sustainable approach to increasing access to evidence-based treatments for perinatal mental health and substance use disorders on a population-based level
- Low-cost approach that can help frontline providers effectively identify and manage perinatal depression



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Beneficence

Fills gaps and builds capacity to support the mental health of youth and perinatal women

Improves outcomes

Reduces stigma

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Nonmaleficence

Does not delay care or send patients on a resource bridge to nowhere

You wouldn't let an asthmatic wheeze for 6 months while waiting on a wait list

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Justice

Helps ensure we are providing the right level of care at the right time

Reduces wait lists so youth and women with more complex diagnoses and symptom sets can get into a higher level of care more quickly

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Goal 4: Describe Texas' CPAN and PeriPAN Access Projects

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The State of Texas is clear that we are in a state of urgency around mental health & that this is a population health issue we must work together to address.

2019

The Texas Legislature creates the Texas Child Mental Health Care Consortium to improve support for primary care clinicians through an Access Project.

We called it CPAN!

The Child Psychiatry Access Network

2020

The Texas Maternal Morbidity and Mortality Review Committee recommends to

"improve integrated behavioral health care access from preconception throughout postpartum for women with mental health and substance use disorders."

2021


The Texas Legislature voted to expand CPAN services to serve clinicians seeing pregnant and postpartum women.

We called it PeriPAN!

The Perinatal Psychiatry Access Network


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CPAN and PeriPAN: Statewide Structure




Health Related Institutions

The 12 state-funded health related institutions of higher education in Texas make up the network for mental health professionals to support providers.




Centralized Operations Support Hub

Centralizes communication and data systems to facilitate coordinated care, allowing providers to call one number.



Laurel L. Williams, DO
Sarah Mallard Wakefield, MD

Serve as Medical Directors
CPAN - Dr. Williams
PeriPAN - Dr. Wakefield



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CPAN and PeriPAN: Statewide Structure

- Dial 1 (Northwest Region)**
 - The University of North Texas Health Science Center at Fort Worth
 - The University of Texas Southwestern Medical Center
 - The University of Texas at Tyler Health Science Center
- Dial 2 (North and East Region)**
 - Baylor College of Medicine
 - The University of Texas Health Science Center at Houston
 - The University of Texas Medical Branch at Galveston
- Dial 3 (Valley and Central Region)**
 - South Medical School of The University of Texas at Austin
 - The University of North Texas Health Science Center at San Antonio
 - The University of North Texas Health Science Center at Dallas
 - Texas A&M University System Health Science Center
- Dial 4 (South Region)**
 - Texas Tech University Health Science Center
 - Texas Tech University Health Science Center at El Paso

Logos for tcmhcc, CPAN, and PeriPAN are at the bottom.

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Goal of our Access Projects: PROVIDE A NETWORK OF SUPPORT FOR YOUTH AND PERINATAL MENTAL HEALTH

- Support providers of youth and maternal health care to identify and manage their patients' mental health
- Expand access to education about youth and maternal mental health disease burden and effective treatments
- Improve the mental health care and systems of care for youth and women who are pregnant, post-partum, suffering perinatal loss or planning pregnancy
- Improve the mental health care and systems of care for Texas children and adolescents, and the women who care for them, by engaging in collaborative care models that improved equity and access to care**

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Core Components of Our Access Projects

- Prompt, phone-based consultation
- Receive clinical guidance in assessment and treatment for presenting mental health symptoms
- Resource navigation and vetted referral services for your patients with complex needs or substance use issues
- Training and education on mental health care for youth and the women who care for them
- Services are state-funded and free to use; clinician's time to initiate consultation is billable for reimbursement

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Training and Education on Mental Healthcare for Youth and the Women Who Care for Them

PeriPAN Webinar Series

Date	Session Title
4/20/2026	Psychopharmacology: Common Psychotropics for Maternal Mental Health Conditions
5/19/2026	Supportive Strategies for Maternal Weight Concerns and Expectations Graduation in the Perinatal Period
5/19/2026	Postpartum Psychosis: Differentiating Outcomes from Intrusive Thoughts
4/25/2026	Maternal Health Challenges Related to Identity
5/19/2026	Maternal Mental Health Conditions and Screening Practices
6/16/2026	Understanding Trauma and PTSD in the Perinatal Population
7/20/2026	Importance of Patient-Centered Care for Improving Perinatal Mental Health
6/18/2026	Impact of Special Health Needs of Neonates on Families
6/18/2026	Assessing Suicide Risk and Implementing Safety Measures in Perinatal Mental Health
10/05/2026	Medication-Assisted Treatment for Substance Use Disorder in the Perinatal Population
11/17/2026	The ACE Study and Its Implications for Generational Mental Health

PeriPAN ECHO Series

Webinar	Topic
W001	Psychopharmacology for Perinatal Depression and Anxiety
W002	Managing Co-Occurring Health Conditions in Women with Perinatal Health Conditions
W003	Post-Partum Support for Parents
W004	Advanced Case Studies on Screening and Management
W005	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W006	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W007	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W008	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W009	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W010	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W011	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis
W012	Case Studies on Postpartum Depression, Postpartum PTSD, and Postpartum Psychosis

QR codes and URLs are provided at the bottom.

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Training and Education on Mental Healthcare for Youth and the Women Who Care for Them

CPAN ECHO Series

Date	Session Title
4/27/2026	Case Studies on Sleep Disorder Treatments
2/24/2026	Case Studies on Eating Disorders
3/24/2026	Risky Behaviors in Adolescents
4/28/2026	Autism Treatments: Clinical Pearls
5/26/2026	Anxiety Disorder Treatments: Clinical Pearls
6/23/2026	Youth and Trauma Exposure: The Effects on Mental Health
7/28/2026	ADHD Behavioral Interventions: Clinical Pearls

CPAN Webinar Series

Date	Session Title
1/13/2026	Sleep Disorders and Mental Health: What Every PCP Should Know
2/19/2026	Eating Disorders: What Every PCP Should Know
3/19/2026	Riskier vs. Personality Development: What Every PCP Should Know
4/14/2026	Autism Spectrum Disorders: What Every PCP Should Know
5/10/2026	Anxiety Disorders in Children and Adolescents: What Every PCP Should Know
6/09/2026	Normal Grief and Loss vs. PTSD
7/16/2026	ADHD Part 1: Uncomplicated ADHD

QR codes and URLs are provided at the bottom.

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Training and Education on Mental Healthcare for Youth and the Women Who Care for Them

SAFETY-A Training

Levels of Training

We are pleased to offer a range of levels of training depending on the unique needs of each clinic and PCP.

SAFETY-A Level	Topic	Hours
SAFETY-A Level 1	Initial overview of SAFETY-A to new attendees SAFETY-A training, right benefits and your role	1-hour Pre-recorded Training video
SAFETY-A Level 2	Basic level knowledge on SAFETY-A with attendees	1-hour Attendee Training
SAFETY-A Level 3	Full overview and competency of SAFETY-A	8 sessions, 7.5-hour Complete Training
SAFETY-A Level 4	Designed to help attendees identify youth and high-risk cases from SAFETY-A	1-hour live training

QR code and URL are provided at the bottom.

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Prompt, Phone-Based Consultation

- Receive clinical guidance in assessment and treatment for presenting mental health symptoms
- Resource navigation and vetted referral services for your patients with complex needs or substance use issues

- One call to obtain a Clinician-to-Clinician (Curbside) Consultation
 - Pediatricians & Pediatric Nurse Practitioners
 - Family Practice Clinicians (Physician, FNP, PA)
 - OB/GYNs
 - Psychiatrists /Psychiatric Mental Health Nurse Practitioners Psychologists
 - Nurse Midwives
- Speak immediately to a clinician who can assist with resources and referrals
- Schedule a return call to speak with a psychiatry specialist that is convenient for you during business hours or ASAP (<30 minutes)
 - Average time is less than 10 mins

No limit on number of calls
No Call is Too Small!

Logos: tcmhcc, CPAN, PeriPAN

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Logos: tcmhcc, CPAN, PeriPAN

Texas now has Access Projects to fill gaps, build capacity, improve outcomes, and reduce stigma to support the mental health of our youth and perinatal women

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Logos: tcmhcc, CPAN, PeriPAN

Goal 5: Identify Barriers to Mental Health Assessment and Treatment in Your Clinical Setting

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Potential Barriers to Improving Mental Health Outcomes

- I have limited experience in assessing for mental health disorders
- I have limited experience in treating mental health disorders
- My clinic does not support me providing mental health care
- My clinical setting does not routinely screen for mental health disorders

Logos: tcmhcc, CPAN, PeriPAN

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Logos: tcmhcc, CPAN, PeriPAN

There are many barriers. CPAN and PeriPAN teams want to help!

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Logos: tcmhcc, CPAN, PeriPAN

Goal 6: Develop Plans for CPAN and PeriPAN Utilization to Improve Patient Care Within Your Practice

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Develop a Plan for CPAN/PeriPAN Utilization

1. Enroll in CPAN or PeriPAN - right now
2. Enter the Phone and Text Line into your cell phone right now
 - Phone: (888) 901-2726
3. Discuss a current case where mental health was a concern- right now (practice calling or texting)
4. Develop screening protocols in your clinic - WHEN TO CALL FOR HELP?
5. Develop workflow that includes contacting CPAN/PeriPAN when a patient:
 - Has a chief complaint of behavioral/mental/substance use concern
 - Screens positive on above screening protocol
 - You have started treatment, and the patient is not improving
 - Patient is in treatment with other mental health providers and you, or the patient/family is concerned that there is not significant improvement

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Our children deserve it.
Our moms deserve it.
You deserve it.
Together we can do this!

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“CPAN is a great asset to me. The intake coordinators are extremely knowledgeable and help me in providing the best care for my patients. The child and adolescent psychiatrists are helpful in advising medication therapy and other treatment modalities or evaluations needed. Having limited resources here in East Texas makes CPAN a necessary part of my treatment strategy for kids.”

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“Mental health services are in desperate need. The PeriPAN program allows me to take excellent care of my pregnant and recently delivered patients. I know I will get good advice with a fast phone call. And I don't have to wait and hope a patient calls their insurance and finds a provider that is accepting new patients in a timely manner.”

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The AAFP Advocates Against Payer Downcoding Policies and For Improved Primary Care Payment

A key priority for the American Academy of Family Physicians (AAFP) is to improve primary care payment while reducing the administrative burdens associated with getting paid. To advance these goals, the AAFP advocates across multiple channels, including actively monitoring and responding to public and private payer policies, especially those that negatively impact primary care practices. In addition to addressing specific payer actions, the AAFP engages in broader advocacy efforts through ongoing dialogue with national stakeholders, participating in coalitions focused on payment reform, and developing tools and resources to support chapters and members in their local efforts.

In recent years, several major commercial payers have implemented policies that automatically lower the E/M code, resulting in lower payments based solely on the diagnosis on the claim submission. Most recently, Cigna Healthcare announced its new Evaluation and Management (E/M) Coding and Accuracy (R49) policy (https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R49_Evaluation_and_Management_Coding_Accuracy.pdf) (effective October 1, 2025), which will permit automatic downcoding of E/M claims without reviewing the supporting clinical documentation.¹ The policy states, "Cigna may adjust the E/M CPT® code 99204-99205, 99214-99215, 99244-99245 to a single level lower when the encounter criteria on the claim does not support the higher level E/M CPT® code reported." Note: Just prior to the publication of this article, Cigna paused their downcoding policy in the state of California (www.cmadocs.org/newsroom/news/view/ArticleId/50993/Cigna-agrees-to-pause-controversial-downcoding-policy).

The AAFP strongly opposes downcoding policies, arguing that this approach ignores CPT guidance which allows office/outpatient E/M coding based on either medical decision-making (MDM) or total time spent on the date of service—factors that cannot be determined from diagnosis codes alone.

WHY IT MATTERS FOR FAMILY PHYSICIANS

Family physicians regularly manage multiple chronic conditions, coordinate care with specialists, address behavioral health and account for social drivers of health—all within the span of a single patient visit. Diagnosis codes do not capture these complexities and cannot be fairly judged by algorithms or claims encounter criteria.

The AAFP warns that automatic downcoding risks:

- Undervaluing the complexity of family medicine
- Increasing administrative burden through appeals
- Straining small and independent practices financially, particularly in rural and underserved areas
- Eroding trust by implying that physicians who code higher-level visits are engaging in fraudulent behavior
- Encouraging inappropriate undercoding, which fails to capture the complexity of care accurately

AAFP RECOMMENDATIONS TO PAYERS

The Academy is urging all payers, but especially those who have established downcoding policies and procedures, to:

- **Pay claims as submitted** unless a clear, documented rationale exists to do otherwise.
- **Clearly and proactively communicate** the program's parameters. Notify physicians when they are identified

CPT GUIDANCE

- E/M CPT code set and reporting guidelines clearly indicate that documentation from the medical record is needed to determine if the level of MDM or total time spent on the date of the encounter has been correctly coded.² This cannot be determined by the primary diagnosis on the claim alone.
- CPT guidance states, "The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."³

as outliers, including a description of the data used and the reasons why, before adjusting individual claims. Offer these physicians additional education.

- **Streamline appeals and determination processes** with an easy-to-use appeals process, making determinations in a timely manner and providing detailed information on the remittance advice if an appeal is denied.
- **Identify a pathway** for being removed from the program. Equip physicians with a clear understanding of the changes or improvements necessary to no longer be considered an outlier and thus removed from the program.
- **Disclose** the use of artificial intelligence (AI), algorithms and analytic solutions. In accordance with the AAFP's Ethical Application of Artificial Intelligence in Family Medicine policy (www.aafp.org/about/policies/all/ethical-ai.html), we urge payers to transparently communicate their methods for executing this program to their in-network physicians and practice managers to offer assurances that determinations are being appropriately made.

The AAFP has also raised (www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/cigna-downcoding-em.html) these concerns directly with Cigna and the insurer advocacy group AHIP (formerly America's Health Insurance Plans), urging them to promote consistency and transparency in downcoding policies across their member plans.⁴ In a formal letter, the AAFP called on AHIP to encourage proactive communication with physicians, streamline appeals processes and disclose the use of AI in payment determinations. The AAFP emphasized that automatic downcoding undermines the complexity of care provided by family physicians. This presumption is likely to lead to inappropriate undercoding, which fails to accurately capture the complexity of care and the resources required to meet patients' needs.

PROTECTING PRIMARY CARE'S VALUES

The AAFP emphasizes that inappropriate downcoding policies could disproportionately harm family physicians, whose practices rely heavily on E/M services. With the United States facing rising rates of chronic disease, the AAFP argues that strong primary care is foundational and critical for both improving patient outcomes and reducing health care costs.

As part of our ongoing advocacy efforts, the AAFP has offered to collaborate with AHIP, Cigna and other payers on educational outreach rather than use

punitive payment cuts. Additionally, the AAFP recently conducted our annual Payer Engagement and Alignment Survey (www.aafp.org/pubs/fpm/issues/2023/1100/beyond-the-beltway.pdf) to assess the degree to which payer behavior aligns with AAFP policies and positions across the following five key domains⁵:

- Reducing administrative burden
- Limiting performance measurement
- Increasing primary care investment and encouraging value-based care progress
- Supporting advanced primary care and population health capabilities
- Protecting physicians' autonomy and scope of practice

Results of the survey inform our ongoing payer engagement strategy and advocacy priorities. The Academy remains committed to ensuring that family physicians are resourced and compensated fairly to provide high-quality, comprehensive care in every community.

STATE CHAPTER ADVOCACY

For those who would like to directly engage with payers in their markets on the issue of downcoding, the AAFP has equipped state chapters with a customizable template letter to support your advocacy against downcoding policies of state and regional health plans. Visit our E/M coding webpage (www.aafp.org/family-physicians/practice-and-career/getting-paid/coding/evaluation-management.html) to access a customizable template letter for opposing downcoding by health plans. You'll also find answers to common coding questions there as well.

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