March 3, 2017

Cynthia G. Tudor, Ph.D.
Acting Director, Center for Medicare

Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director, Parts C & D Actuarial Group
Office of the Actuary

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Director Tudor and Director Wuggazer Lazio:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the "Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018" call letter as posted by the Centers for Medicare & Medicaid Services (CMS) on February 1, 2017.

Before providing the AAFP's comments to the policies proposed in the call letter, we offer the following recommendations to improve the Medicare Advantage program:

- **Improve the Annual Wellness Visit -** The AAFP continues to be concerned with the inappropriate use of the annual wellness visit (AWV) by commercial entities that are independent of physician practices in both the traditional Medicare and Medicare Advantage programs. In other venues, CMS has stated 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 recommends that CMS also apply this policy to AWV in Part B and Part C. Doing so would address ongoing concerns over the potential misuse of the AWV by commercial entities. The AAFP maintains that the AWV 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. As such, we believe that Medicare should only pay for AWVs in the patient's primary care practice. We remain concerned that there are commercial entities that are subverting the AWV benefit and may be misleading patients. We and others have spoken with CMS staff about these concerns in the past and would welcome the opportunity to do so again.
- **Narrowing Networks -** The AAFP continues to have severe concerns with the potential for decreased access caused by mergers and acquisitions in the health insurance industry.

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Mergers may result in decreased choice for consumers and higher costs for purchasers and may potentially establish mass disruptions in continuity of care due to changing and narrowing networks of physicians and hospitals. Churn is real and undermines the medical home. Our concerns are fundamental to the role of competition in driving innovation, improving quality in care delivery, and reducing costs. On January 12, 2015, AAFP submitted a statement concerning network adequacy to the National Association of Insurance Commissioners. The AAFP cautions that proposals should not promote the practice of unilaterally rescinding physicians from networks without cause or appeal.

- **Inconsistent Claims Review Process -** Medicare physicians are currently subject to claims review by multiple HHS contractors including Medicare Administrative Contractors, Medicare and Medicaid Recovery Audit Contractors, Medicaid Integrity Contractors, and Comprehensive Error Rate Testing Contractors. Additionally, family physicians find themselves subjected to review by Medicare Advantage plans seeking to validate the risk adjustment scores those plans receive from Medicare. These redundant, inconsistent, and overlapping audits place an enormous and unfunded administrative burden on practicing physicians, and the AAFP urges HHS to streamline and coordinate these efforts.
- **Traditional Medicare and Medicare Advantage Payment –** Medicare Advantage plan payments to physicians must be at least Medicare fee-for-service payments.
- **Address Beneficiary Cost-Sharing for Primary Care Services –** The AAFP continues to advocate that patients not be subject to cost-sharing for any primary care service. Cost sharing is designed to decrease utilization, and primary care is underutilized in the U.S. health system. The AAFP encourages CMS to seek authority to waive coinsurance and deductibles for the chronic care management, complex chronic care management code, and other important primary care services.
- **Time Wasted on Prior Authorization Paperwork –** A significant unfunded mandate burdening family physicians is the frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorization from a Prescription Drug Plan (Part D) or Medicare Advantage Plan (Part C). Frequent formulary changes by drug and health plans and their time-consuming pre-authorization requirements impede the practice of medicine. The AAFP suggests that CMS require Part D and Part C plans to pay physicians for prior authorizations that exceed a specified number or that are not resolved within a set period of time; prohibit repeated prior authorizations for ongoing use of a drug by patients with chronic disease; prohibit prior authorizations for standard and inexpensive drugs; and require that all plans use a standard prior authorization form. The AAFP urges CMS to require all Part C and D plans adhere to the joint principles on prior authorization that AAFP developed with other physician organizations.
- **Medicare Advantage All-Payer Option -** Medicare Advantage continues to grow as an important coverage option. In 2010, 11.1 million beneficiaries were enrolled in an MA plan. As of 2016, 17.6 million beneficiaries are enrolled under an MA plan. Under the *Medicare Access and CHIP Reauthorization Act* (MACRA) final rule, family physicians may qualify under MA in the All-Payer Option.

In order to improve the Medicare Advantage and Prescription Drug Plan programs, the AAFP offers the following reactions to the 2018 draft call letter.

Quality Measures
In this call letter, CMS discusses new and returning measures for 2018, changes to measures for 2018, and removal of measures from the Star Ratings methodology.

AAFP Response
The AAFP believes more work must be done to harmonize quality and performance measures. This harmonization should focus on aligning measures across all public and private payers, including Medicare Advantage plans. Physicians, especially family physicians, bear the brunt of quality and performance measurement. A major part of this load is the burden of multiple performance measures in quality improvement programs with no standardization or harmonization. The AAFP recommends that CMS use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures among all payers.

Part D Formulary Submissions
The call letter states that the 2018 formulary submission window will open on May 15, 2017, and close on June 5, 2017. CMS must be in receipt of a successfully submitted and validated formulary submission by the deadline of June 5, 2017, in order for the formulary to be considered for review.

CMS also proposes that Part D plans will need to implement formulary safeguards, so patients do not receive too large a dose of opioids. The cut-off is two times the cumulative morphine equivalent dose suggested by the Centers for Disease Control and Prevention (CDC) in its opioid guidelines, or 200 mg of morphine. The agency also calls for other safeguards by plans to try and eliminate patients from getting opioid prescriptions from multiple providers or filling prescriptions at multiple pharmacies to prevent abuse of the powerful pain relievers.

AAFP Response
The AAFP urges CMS, Medicare Advantage organizations, Prescription Drug Plan sponsors, and other interested parties to consult the AAFP's policy on Patient-Centered Formularies while making formulary policies.

The AAFP appreciates that CMS is taking further steps to address the abuse of opioid medication. Therefore, we are hopeful these requirements decrease abuse and improve outcomes without decreasing access for those patients who may need opioids. Our main concern is the use of the CDC guideline to set limits. The AAFP supported many parts of this guideline but also expressed concern with it since it lacked evidence. The guideline makes several strong recommendations that are based on consensus opinion because quality studies are lacking. The AAFP is concerned with basing policy on a guideline that lacks a strong evidence base, no matter how well-intended the guideline. The AAFP is concerned with basing policy on a guideline that lacks an evidence base, no matter how well-intended the guideline. Furthermore, prescribing guidelines are made to assist clinicians in making clinical decisions and must not create rules that restrict clinical decisions or penalize clinicians.

Network Adequacy Determinations
CMS states that the Medicare medical provider and facility portion of a Medicare-Medicaid Plan's (MMP) network information will be due to CMS on the third Tuesday in September 2017. CMS claims this submission will ensure that each MMP continues to maintain a network of providers that is sufficient in number, variety, and geographic distribution to meet the needs of the enrollees in its service area.

AAFP Response
The AAFP thanks CMS for its dedication to improving the information available to Medicare Advantage (MA) beneficiaries regarding plan networks. Without accurate and up-to-date provider directories, beneficiaries face unfair, costly, and protracted obstacles to receive the care they need. In the case of family medicine and primary care, accurate and up-to-date physician directories ensure health care's main entry point stays open and easily accessible to seniors.

When implementing regulatory requirements to verify networks are adequate and provider directories are current, the AAFP believes physicians have a part to contribute but would urge CMS to place the bulk of the onus on Medicare Advantage Organizations (MAOs). When MAOs generate their provider directories, they should set the information technology infrastructure in a way that does not create an additional, overly burdensome reporting requirement for providers. For example, the regular communications with physicians to ascertain whether they are accepting new patients, in addition to updating their practice contact and availability information, should be communicated electronically and by mobile phone texting in addition to regular mail. Furthermore, those electronic communications should have an embedded hyperlink to a webpage for the MAO's provider directory. Any changes or updates the physician makes on that webpage regarding their information and availability, should update the MAO's online provider directory instantaneously. Since they are so many MAOs, the AAFP urges CMS to require that provider information for directories be standardized and that each MAO should only collect:

- Provider name
- Practice street address, city, state, zip code, phone number, website
- Practice office hours and other information that could affect availability
- Whether the provider is taking new patients
- The anticipated time period of accepting or not accepting new patients

The webpage for physicians to change or update their information should be pre-populated with the insurance products and networks in which the physician is currently participating, thereby reminding the physician of his or her plan participation. The webpage's user interface should be easy for physicians to understand and navigate and follow best practices established within the e-commerce domain:

1. Within the form, the field names should be short and precise to tell physicians what information to complete for the related input fields.
2. Appropriately name the different sequential steps to help physicians understand the purpose of providing the inputs (i.e., accepting new patients or not, anticipated time period of accepting or not accepting new patients, practice contact information, full-time equivalents, and other information affecting availability).
3. Give the number of steps to complete the updating process and on which step the physician is during the updating process.
4. Give a confirmation message to the physician in any update step to help them confirm they are on the right track to complete the process.
5. Offer physicians help exactly where and when it's needed during the updating process.

Most likely, physicians will be changing whether they are accepting new patients throughout the year. Therefore, the MAO's website for physicians should have a check-box feature that is easily accessible for them to check when they are taking new patients or un-check when they are not taking new patients or are unavailable. In addition, that crucial piece of information must be updated on the MAO's online provider directory instantly. Lastly, AAFP believes quarterly

communications to be a reasonable time period for communications between MAOs and physicians.

If CMS moves forward with creating a nationwide Medicare Advantage provider database, the AAFP would like to reiterate its position that physicians play a key part, but MAO's should provide the bulk of the information. Network information should be aggregated directly from the MAO's accurate and up-to-date provider directories. Physicians should not be expected to go to another website to update the nationwide provider database.

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair