AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 6, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4190–P
P.O. Box 8013
Baltimore, MD 21244–8013

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the proposed rule titled, "Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elder" as published by the Centers for Medicare & Medicaid Services (CMS) in the February 18, 2020 *Federal Register*.

This rule proposes revised regulations to implement certain sections of the *Bipartisan Budget Act*, the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*, and the *21st Century Cures Act*.

Medicare Advantage (MA) and Puerto Rico

Summary

Recognizing that a far greater proportion of Medicare beneficiaries receive benefits through MA in Puerto Rico than in any other state or territory, CMS proposes policies for 2021 to provide stability for the MA program in the Commonwealth and to Puerto Ricans enrolled in MA plans. These policies include basing the MA county rates in Puerto Rico on the relatively higher costs of beneficiaries in fee-for-service who have both Medicare Parts A and B, continuing the statutory interpretation that permits certain counties in Puerto Rico to qualify for an increased quality bonus adjusted benchmark, and applying an adjustment to reflect the nationwide propensity of beneficiaries with zero claims.

AAFP Response

The AAFP appreciates that CMS is addressing these issues. Puerto Rico consistently receives a lower floor rate compared to the 50 States and DC per provisions of the *Balance Budget Act*, *Benefits Improvement and Protection Act*, and the *Affordable Care Act*. Despite past increases, there is still a large disparity in Medicare Advantage capitation per county, with counties in Puerto Rico receiving an average per month of $583 compared to the United States average of $988.

The AAFP supports equitable funding for Medicare Advantage in Puerto Rico, the U.S. territories, the 50 states and the District of Columbia. We likewise support efforts to

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remove funding disparities among Puerto Rico, the U.S. territories, the 50 states, and the District of Columbia.

Require Part D plans to provide an online price comparison tool

Summary

CMS proposes that each Part D plan implement a Beneficiary Real Time Benefit Tool (RTBT) that will allow enrollees to view plan-provided, patient-specific, real-time formulary and benefit information by January 1, 2022. This tool will display up-to-date information on prescription drug benefits and estimates, as well as alternatives to prescriptions.

AAFP Response

The AAFP supports efforts to require plans to disclose cost-sharing information to patients via websites. Americans are becoming more accustomed to researching the price of almost anything online and posting cost-sharing data will make it easier for patients to shop around for the best price. Improving access to cost, quality, and population health management information related to services furnished to their patients by other providers will enable family physicians and their patients to make better informed decisions that consider both cost and quality.

Price transparency is critically important for value-based care, and the AAFP supports steps to improve patient awareness of healthcare costs, including prescription drug costs. Though transparency policies do not directly lower healthcare costs, the information provides more data that would allow patients and physicians to make more informed treatment choices.

Requiring Part D plans to implement drug management programs

Summary

Starting in 2022 and per provisions of the *SUPPORT Act*, CMS proposes to require Part D plans to educate beneficiaries on opioid risks, alternate pain treatments, and safe disposal of opioids. The proposed rule also expands drug management programs and medication therapy management programs, through which Part D plans review with providers opioid utilization trends that may put beneficiaries at-risk and provide beneficiary-centric interventions.

AAFP Response

The AAFP supports these steps as they will help prevent and treat opioid overuse.

Beneficiary access to specialists via telehealth

Summary

CMS proposes new policies to address network adequacy concerns for MA plans by encouraging the use of telehealth in all areas. In rural areas, CMS proposes to reduce the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90% to 85%. To encourage and account for telehealth providers in contracted networks, CMS proposes that MA plans receive a 10% credit toward the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for Dermatology, Psychiatry, Cardiology, Otolaryngology, and Neurology. CMS seeks input on whether to expand this credit to other specialty provider types.

AAFP Response

Regarding the proposed policy for these specified five sub-specialties to receive credit toward network adequacy standards, at this time the AAFP is not concerned but we urge CMS to

carefully monitor plans to ensure network adequacy standards only encourage higher quality, lower costs, and strong patient-physician relationships.

Regarding network adequacy, the AAFP welcomes an opportunity to work with the Administration on ensuring appropriate access to family physicians. The fluidity of MA networks coupled with the one-sided, insurance-dominated, contracting process should be more fully evaluated and reformed. Rather than identifying specific medical sub-specialties as proposed, **it is our general position that all family physicians should be eligible to participate in the network of all MA plans in their area if the family physician chooses to participate and unless there are extraordinary reasons for exclusion.**

We encourage CMS to examine network adequacy as a factor in identifying core health services in rural communities. Strong network adequacy standards promote the primary care medical home model as a way to deliver higher quality, lower costs, and a stronger patient-physician relationship. A study in *JAMA Internal Medicine* reported that the supply of primary care physicians is associated with lower mortality rates. This suggests that the supply of primary care physicians impacts population health. Primary care capacity should be the focal point of network adequacy, and CMS should examine the percentages of family physicians and other primary care physicians participating in rural areas. Additionally, when determining network adequacy, the ratios for primary care physicians to covered persons and for physicians to covered persons by specialty should reflect physician full-time equivalents, because physicians may practice part-time or in multiple locations. In addition, nonphysician providers (i.e., nurse practitioners and physician assistants) should not be counted, because listing these providers creates the illusion that there is more access to physicians.

The AAFP's longstanding policy on team-based care encourages health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician. **Family physicians are particularly qualified to lead the health care team, because they possess the skills, training, experience, knowledge, and leadership needed to provide comprehensive medical care, health maintenance, and preventive services for a range of medical and behavioral health issues.**

Overhaul MA and Part D star ratings

Summary

In addition to routine measure updates to the Star Ratings, CMS proposes to further increase the predictability and stability in the Star Ratings by directly reducing the influence of outliers on cut points and by increasing measure weights for patient experience/complaints and access measures from two to four.

AAFP Response

The AAFP reviewed the proposal and supports CMS increasing the weight of the patient experience and access measures from two to four. The AAFP supports increasing the voice of the patient in rating their health plans, and we agree that the statistical reliability of the patient experience and access measures is high.

Proposed New Measures

Summary

CMS proposes the following new measures:

- Transitions of Care (Part C): The HEDIS Transitions of Care measure is the percent of discharges for members 18 years or older who have each of the four indicators during the measurement year: (1) notification of inpatient admission and discharge; (2) receipt of discharge information; (3) patient engagement after inpatient discharge; and (4) medication reconciliation post discharge.
- Follow-Up After Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C): CMS is proposing to add a new HEDIS measure assessing follow-up care provided after an emergency department (ED) visit for patients with multiple chronic conditions. This measure is the percentage of ED visits for members 18 years and older who have high-risk multiple chronic conditions who had a follow-up service within 7 days of the ED visit between January 1 and December 24 of the measurement year. The measure is based on ED visits, not members.

AAFP Response
Regarding transitions of care, the AAFP agrees with use of this measure at the plan level pending NQF endorsement to assess the percentage of discharges who had each of four indicators following discharge. This is a good process measure and may improve care coordination between hospitals and the primary care physician. However, patients may not understand the complexity of the measure and data collection may be challenging as data abstraction is necessary. Plans often require physicians to submit records for abstraction, which places a considerable burden on physician practices. Physician feedback should be gathered on the administrative burden of this measure and used to determine the feasibility of data collection prior to NQF endorsement. Electronic reporting should replace he hybrid nature of this measure as soon as possible.

Regarding follow-up after ED visit, the AAFP agrees with use of this measure at the plan level pending NQF endorsement. The measure should encourage plans to improve care coordination between patients seen in the ED and the primary care physician. There is potential for this measure to be met using a checkbox, particularly with telephone follow-up, which is not meaningful nor indicative of the quality of the follow-up. Additionally, it is challenging for the primary care physician to follow-up within the timeframe if there is not timely notification from the ED. The AAFP encourages timely notification of ED visit and use of alternative data sources, such as electronic data extraction as soon as available to meet the measure.

We remind CMS that even though these measures are for plans, data collection efforts and results trickle down to physicians. During the most recent review of Parts C & D measures at the MAP Clinician Workgroup, the AAFP and other primary care organizations emphasized the burden placed on physician practices by health plans collecting data for use in HEDIS reporting. Practices are expected to retrieve, copy, and submit large amounts of data to support HEDIS plan measurement and audits. This comes at a high cost in time and money to the practice, for which they receive no reimbursement. For this reason, measure burden must be kept low, as physicians are the ones who bear the ultimate burden of data submission when data abstraction is required, as in the case of hybrid measures.

Finally, CMS proposed reclassification of the measure “Statin Use in Persons with Diabetes” (Part D measure) to a process measure and we agree with this proposal. However, we would like to point out that this measure along with other measures that examine medication adherence or use medication fills/fill-rates may lead to inaccurate results. For example, patients may pay with cash or use “Good Rx” or other discount services; instead of their insurance plan;

physicians may prescribe medications that can be divided to reduce medication costs; if medication strength is changed patients may be able to split/divide current supply which throws-off calculations; refill information is not always accurate/reliable when patients change pharmacy plans or physicians.

To the extent possible MA Stars measures should be aligned with performance measures from other programs, including the Quality Payment Program (MIPS and APMs) and to those identified by the Core Quality Measures Collaborative.

Request for Additional Measures

Summary

CMS requests input from the public on additional measures for the Medicare Advantage program.

AAFP Response

The AAFP recommends the addition of the following measures for MA (Part C) performance evaluation:

- Prior Authorizations: - Prior authorization is a health plan utilization management tool that requires physicians and others to solicit approval from a patient's health plan to proceed with scheduling a service. Health plans evaluate whether the service is covered by the patient's plan and is medically necessary. Approval of a prior authorization request does not guarantee payment for the service. Prior authorization has traditionally been used to ensure appropriate use of new or high cost diagnostics and therapies.

  When instituted appropriately, prior authorization can help align patient care with health plan benefits and facilitates compliance with clinical best practices. However, prior authorization requirements and processes vary widely, even among different health plan products offered by the same issuer, and they can create dangerous delays in care delivery when not applied appropriately. They also can create confusion and burden for both patients and physicians, leading to additional administrative costs for the health care system.

  The MA Star Ratings Program provides a useful mechanism to monitor the impact of prior authorization processes on patients, and we encourage CMS to develop a prior authorization measure that accounts for the following three elements:

  - Average time for a response: Uncertainty as to whether the care recommended by your physician can be received, and if so, when it can be, is extremely stressful for patients. For a physician, having to delay treatment until a health plan makes a prior authorization determination can be an administrative hassle and, more importantly, can potentially lead to worsening patient health outcomes. According to a 2018 American Medical Association survey, 91% of physicians report that prior authorization has led to a delay in patient access to care. To minimize care delays caused by prior authorization and increase predictability of decision-making, health plans should be required to respond to prior authorizations in a timely manner. The AAFP urges CMS to follow the AMA Prior Authorization and Utilization Management Reform Principles that call for MA Star Ratings to measure the median time from submission of a complete prior authorization request until the health plan decision is transmitted back, with

expectations being that the average time is no more than 48 hours for non-urgent care procedures and 24 hours for urgent care. Decisions for expedited appeals should be communicated within 24 hours. Results of all other appeals should be communicated with in 10 calendar days.

- Approval rates/denial rates: While the goals of ensuring appropriate care and prudent allocation of resources are valuable objectives for health plans, the prior authorization process is inherently burdensome and can result in care delays. As a result, prior authorization plans should be used judiciously. Accordingly, CMS should measure the approval rates for prior authorizations by services and set a standard for when a service should be "retired" from prior authorization requirements, such as when requests for such a service are routinely approved more than 90% of the time. In such instances, health plans should pursue alternative means of identifying and addressing outlier physicians that do not burden the more than 90% of physicians adhering to clinical criteria. For instance, health plans might exempt physicians whose prior authorizations for a service are approved 90% of the time while continuing to subject those below that threshold to prior authorization.
- Appeal overturn rate: When health plans improperly deny prior authorizations for medically appropriate drugs or procedures, a patient care plan is disrupted, and their health is jeopardized. Unfortunately, physicians, hospitals, and other health care providers frequently experience situations where a clearly medically necessary service is denied. The Department of Health and Human Services Office of Inspector General issued a September 2018 audit report detailing the routine denial of prior authorization for medically necessary care among MA plans. It found that approximately 75% of beneficiary and provider appeals of MA plan denials were successful. To help protect patients from being inappropriately denied access to necessary medical care, CMS should measure the rate at which appeals for denied care are successful and establish a threshold over which a plan is determined to have an excessive denial rate.

Extend MA eligibility to patients with end-stage renal disease

Summary

Per the *21st Century Cures Act*, CMS is extending eligibility to MA patients with end-stage renal disease.

AAFP Response

The AAFP fully supports this proposal.

Codify MA and Part D policies into an annual regulation

Summary

CMS seeks comment from the public on proposals to codify many longstanding policies on the MA and Part D programs into regulation. These have previously been adopted through sub-regulatory guidance such as the annual Call Letter and other guidance documents.

AAFP Response

The AAFP fully agrees with CMS in that codifying the policies in regulation provides additional transparency and program stability.

Request for Information on rural access to telehealth

Summary
Without making a proposal, CMS seeks feedback on additional changes to be made to MA to allow more beneficiaries in rural areas to access telehealth.

AAFP Response
The AAFP encourages CMS to review a letter we sent the Health Resources and Services Administration on October 9, 2019. In it, the AAFP discusses the underlying reasons for rural health care concerns are multifactorial but include lower payments family physicians receive under Medicaid, the closure of many rural hospitals, the impact of hospital and insurance consolidation, greater impact of poorly functioning, high cost electronic health records on solo and small independent practices, and the poor recovery of rural communities after the economic downturn.

Care must be taken that telemedicine improves rural health systems rather than cause disruption. Family physicians will continue to need to see rural patients in person in clinics, ERs, and hospitals. Medical and obstetrical emergencies require immediate procedural response. Telemedicine services that reduce the number of physicians caring for rural communities will lead to worse outcomes.

Medical Loss Ratio (MLR)
Summary
CMS proposes to allow MA organizations to include in the MLR numerator as "incurred claims" all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of "provider." In addition, CMS proposes to add a deductible-based adjustment to the MLR calculation for MA medical savings account contracts receiving a credibility adjustment.

AAFP Response
The AAFP supports strong MLR policies as they help ensure health care finances are focused on patient care rather than insurer profits. With patient care in mind, we encourage CMS to carefully monitor and correct potential unintended consequences with these changes.

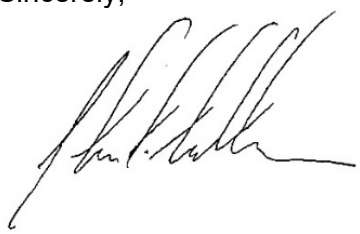
Special Election Periods (SEPs)
Summary
CMS proposes to codify several SEPs the agency adopted as exceptional circumstances SEPs. Among the SEPs are ones for:

- Individuals Affected by a Federal Emergency Management Agency-Declared Weather-Related Emergency or Major Disaster
- Employer/Union Group Health Plan elections
- Individuals Who Disenroll in Connection with a CMS Sanction
- Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer
- Individuals Enrolled in a Plan Placed in Receivership.

AAFP Response
The AAFP supports the existence of SEPs and agrees with the agency that codifying these SEPs will provide transparency and stability for stakeholders

Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 or rbennett@aafp.org with any questions or to engage the AAFP further.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair