AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

February 27, 2018

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave.
Washington, DC, 20201

Dear Principal Deputy Administrator and Director Kouzoukas:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the document titled "Part II of the 2019 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies and Draft Call Letter" as made available by the Centers for Medicare & Medicaid Services (CMS) on February 1, 2018.

We hope the agency is thoroughly reviewing and using the AAFP's comment letter filed January 16, 2018, in response to the "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program" proposed rule. The AAFP continues to share CMS' goal to create more choices for Medicare beneficiaries selecting MA and Part D plans in 2019. We look forward to reviewing the final policies for the 2019 plan year that the agency is expected to publish on April 2, 2018. Within the Part II letter, the AAFP notes two areas of interest to family physicians.

Transparency & Timeliness with Prior Authorization Processes
The AAFP appreciates that CMS recognizes concerns about the burdens imposed by coverage restrictions such as prior authorizations (PA) in the Part C program. Likewise, we appreciate that CMS, in this letter, is reminding MA plans they should be transparent and provide adequate notice of any coverage restrictions to physicians and enrollees. The AAFP maintains that the current regulatory framework with which primary care physicians must comply is daunting and often demoralizing. Standardization is not required among public or private payers as it should be, and many family physicians participate with 10 or more payers. Physicians must navigate rules and forms for each payer. As a result, physicians spend needless hours reviewing documents and literally checking boxes to meet the requirements of each health insurance plan. This is time physicians could better spend caring for patients and improving that care.

Therefore, the AAFP adamantly urges CMS to take further steps beyond merely reminding and encouraging plans to address the frequent phone calls, faxes, and forms physicians and their staff must manage to obtain PAs from MA plans, prescription drug plans, and durable medical equipment (DME) suppliers. Physicians strive to deliver high-quality medical care in an efficient manner. The AAFP urges CMS to require and enforce the following PA principles on MA and Part D plans:

- Activities requiring PA must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control.
- Rules and criteria for PA determination must be transparent and available to the prescribing physician at the point of care. If a service or medication is denied, the reviewing entity should provide the physician with the reasons for denial. For medications, it should provide alternative choices.
- PA should be eliminated for physicians with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship.
- There should be a goal of eliminating PA for DME, imaging, supplies, and generic drugs.

The AAFP strongly encourages CMS to execute the following transitional steps among payers that contract with Medicare (e.g. MA and Part D plans) to improve the burdensome PA process:

- Limiting and reducing the number of products and services requiring PA
- Adopting a standardized form and process for PA among all payers
- Requiring payers and pharmacy benefit managers (PBMs) that design PA specifically to save the payer or PBM money rather than benefit the patient to pay physicians for their time, as decided by the 2008 *Merck-Medco v. Gibson* court case
- Requiring payers to pay physicians for PAs that exceed a specified number or are not resolved within a set time-period
- Prohibiting payers from requiring repeated PAs for effective medication management for patients with chronic disease and PA for standard and inexpensive drugs.

Improving Drug Utilization Review Controls in Medicare Part D

The AAFP agrees with the agency's concern, discussed in the Part II letter, that opioid medications have serious risks such as addiction, overdose, and death. As articulated in a February 14, 2018, letter to the Senate Finance Committee in response to their request for policy recommendations and feedback to inform deliberations on the opioid epidemic, the AAFP fully recognizes the intertwined public health issues of chronic pain management and the risks of opioid misuse. We understand that high levels of misuse and addiction persist with devastating consequences despite annual decreases in the number of opioids prescribed in the United States since 2010.

To promote evidence-based care for patients with chronic pain while minimizing the risk of opioid and other substance use disorders (OUD/SUD), we must recognize that both pain management and dependence therapy require patient-centered, compassionate care as the foundation of treatment. These are attributes that family physicians bring to their relationships with patients. It is unfortunate that the payment and regulatory framework for physician practices has reduced face-to-face time with patients, making it more difficult for physicians and patients alike. Our current payment models, coupled with a crippling regulatory structure, threaten access for millions of patients to evidence-based pain care and OUD and SUD treatment from primary care physicians. The AAFP suggests that CMS, MA plans and Part D plans provide incentives to encourage patients to see their primary care physicians to access Screening, Brief Intervention, and Referral to Treatment (SBIRT) for OUD/SUD.

In the face of opioid misuse, family physicians have a unique opportunity to be part of the solution. Effective pain management should be coordinated by a primary care physician who best knows the patient. Effective pain management should also be integrated into continuous, comprehensive whole-patient care. Payment incentives could be used to reduce or remove co-pays for screening and treatment for OUD and SUD. Incentives should also be used to support the appropriate co-

prescribing of naloxone as the AAFP outlines on the AAFP website. CMS should also ensure coverage for medication-assisted treatment (MAT) and other evidence-based treatments for OUD. While the evidence is still evolving on the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for opioids, SBIRT is recommended by the Substance Abuse and Mental Health Services Administration and others and could be implemented like screening for tobacco and alcohol misuse. The AAFP has screening tools and other resources in our Chronic Pain Management Toolkit.

The AAFP opposes limiting patient access to any physician-prescribed pharmaceutical without cause, as well as any actions that limit physicians' ability to prescribe these products based on the physician's medical specialty.

The AAFP supports effective state prescription drug monitoring programs (PDMP) that facilitate the interstate exchange of registry information as called for under the *National All Schedules Prescription Electronic Reporting Act*. We advocate for physicians to use their state PDMP before prescribing any potentially abused pharmaceutical product. However, the success of such efforts depends on state reporting systems that are accessible, timely, interoperable, and comprehensive. We must work together to make prescription drug monitoring effective for the sake of the public's health. The AAFP supports an interoperable secure national database to support a robust National Prescription Drug Monitoring Program. Until the United States has a National PDMP, the AAFP and our 54 chapters will continue working to encourage the use of state PDMPs and bring localized and state specific education to our members and their care teams.

The current opioid crisis is having an overwhelming impact on America's overall health and well-being, which translates to increased trauma for children, families, and communities. Unfortunately, payment for primary care office visits with a mental health diagnosis code has traditionally been discounted or proscribed by private insurance, Medicaid, and Medicare as detailed in the AAFP's Mental Health Care Services by Family Physicians (Position Paper). Many managed care plans do not pay family physicians for the provision of mental and behavioral health care, even though family physicians are frequently in the position to diagnose, treat and provide the needed care. We encourage CMS and MA plans to adequately pay for prevention programs and counseling/outreach programs to support the children and families impacted by OUD and SUD.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair

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.