AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-2024-0006; Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to provide comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

More than half of eligible Medicare enrollees are in Medicare Advantage (MA) plans.[1] By 2030, it is estimated that 60 percent of eligible enrollees will choose an MA plan over traditional Medicare.[2] While MA enrollment continues to grow rapidly, market forces and policy modifications are placing downward pressure on MA plans that may have the unintended consequence of creating disincentives to promote high-value care and improved health outcomes. Family physicians care for many patients who rely on MA and Medicare Part D prescription drug coverage, and as such, are well positioned to provide information regarding how MA plans impact beneficiary health.

We appreciate the opportunity to offer comment on the following proposals:

- Improvements to drug coverage as mandated by the Inflation Reduction Act;
- Additional adjustment to FFS per capita cost estimates for Puerto Rico

<u>Implementation of the Inflation Reduction Act</u>

The Advance Notice continues to implement provisions of the Inflation Reduction Act which lower prescription drug costs, building upon previously implemented provisions such as eliminating cost-sharing for Part D vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and capping insulin costs at $35 per month. The 2025 CY updates include an annual $2,000 limit on out-of-pocket costs. Family physicians regularly see patients who cannot afford their medications and thus, cannot adhere to treatment recommendations. Cost concerns are cited as the most common reason Medicare beneficiaries decide to not fill a prescription.[3] In some cases, patients reduce spending on other necessities such as food or utilities to afford medications, which also has an adverse effect on health.[4] Reducing out-of-pocket costs will help more Medicare beneficiaries

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follow recommended treatment. **The AAFP applauds CMS' implementation of IRA provisions to reduce the cost burden of prescription drugs for Medicare beneficiaries.**

Additional Adjustment to FFS per Capita Costs in Puerto Rico

CMS proposes to continue adjustments to the calculations used to estimate the FFS per capita cost estimate in Puerto Rico. Medicare Advantage rates are based on the FFS per capita cost estimate, and because Puerto Rico has much lower enrollment Medicare Parts A and B than other geographies, a modified methodology is necessary to correctly estimate average FFS costs.

The AAFP strongly supports adjustments to the methodology used to estimate FFS costs in Puerto Rico. Ninety-four percent of all Medicare beneficiaries are enrolled in an MA plan in Puerto Rico,[5] which suggests FFS cost estimates would be based on a sample of less than 10% of Medicare beneficiaries in Puerto Rico. Further, a higher proportion of FFS beneficiaries in Puerto Rico show no utilization (zero claims) compared to the proportion of FFS beneficiaries nationally with zero claims.[6] Given the limited sample size and abnormal utilization patterns within this small group, adjustments are necessary to develop a true estimate of average FFS per capita cost.

The AAFP appreciates the adjustments CMS proposes to continue in 2025, including inpatient claims repricing, adjustments to the weighting of FFS beneficiaries with zero claims, and removing beneficiaries who are not enrolled in both Parts A and B. CMS seeks comment on alternate adjustments for Puerto Rico, recognizing the limits of their authority to make changes.

On page 23 of the 2020 Announcement of CY 2020 MA Capitation Rates, CMS provided additional commentary regarding the agency's authority to adjust the methodology used to calculate average FFS cost, referencing section 1876(a)(4) of the Social Security Act and the term, "adjusted average per capita cost." Section 1876(a)(4) states:

> *For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) …*

We strongly urge CMS to consider whether the number of FFS claims available for Puerto Rico reflects an "adequate sample" as described above, and if not, to make additional adjustments to ensure the FFS cost estimate reflects the actual per capita cost to care for an average MA beneficiary in Puerto Rico. We are concerned that the FFS sample is not representative of MA beneficiary characteristics (such as income or disability) which is linked to utilization patterns, which in turn, impact the precision of the FFS cost estimate. For example, there is evidence of variable utilization of primary care services between the FFS, dual-eligible, and MA beneficiary populations in Puerto Rico.[7] The statute also suggests the Secretary use "other information and data" to make accurate estimates.

We support comparisons to national averages or similar geographies to improve the accuracy of the FFS per capita cost estimate. This includes setting an average geographic adjustment (AGA) based on a national average or budget neutral floor or applying the AGA from a comparable geography, such as the United States Virgin Islands.

Thank you for the opportunity to offer comment. If you have additional questions, please contact Julie Riley, Regulatory and Policy Strategist, at jriley@aafp.org or 202-655-4934.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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[1] M Freed, A Damico, J Fuglesten Biniek, T Neuman, "Medicare Advantage 2024 Spotlight: First Look," KFF, November 15, 2023. Accessed: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/

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[3] Kennedy J, Tuleu I, Mackay K. Unfilled Prescriptions of Medicare Beneficiaries: Prevalence, Reasons, and Types of Medicines Prescribed. J Manag Care Spec Pharm. 2020 Aug;26(8):935-942. doi: 10.18553/jmcp.2020.26.8.935. PMID: 32715958; PMCID: PMC10391240. https://pubmed.ncbi.nlm.nih.gov/32715958/

[4] Rohatgi KW, Humble S, McQueen A, Hunleth JM, Chang SH, Herrick CJ, James AS. Medication Adherence and Characteristics of Patients Who Spend Less on Basic Needs to Afford Medications. J Am Board Fam Med. 2021 May-Jun;34(3):561-570. doi: 10.3122/jabfm.2021.03.200361. PMID: 34088816; PMCID: PMC8824724. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8824724/#:~:text=Particularly%20among%20people%20with%20low,clothing%2C%20housing%2C%20and%20transportation.

[5] Nancy Ochieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman. "Medicare Advantage in 2023: Enrollment Update and Key Trends," KFF, Aug 9, 2023. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[6] The Moran Co. Analysis of Puerto Rico fee-for-service Medicare experience: implications for setting Medicare Advantage benchmarks. January 2017. Accessed February 19, 2024. https://mmapapr.org/wp-content/uploads/2018/12/Analysis-of-Puerto-Rico-Fee-For-Service.pdf

[7] *Ibid.*