AMERICAN ACADEMY OF FAMILY PHYSICIANS

March 3, 2023

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

Re: CMS-2023-0010; Advance Notice of Methodological Changes for Calendar Year (CY) 2024 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 127,600 family physicians and medical students across the country, I write to provide comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

Implementation of the Inflation Reduction Act

As required by the Inflation Reduction Act (IRA), this advanced notice would remove cost-sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) under Medicare Part D. The AAFP has long supported policies to ensure the availability of effective, safe, and affordable vaccines and to eliminate financial barriers to adult vaccines for all beneficiaries, including those under Medicare Part D and Medicaid. It's estimated that more than 50,000 adults die from vaccine-preventable diseases, excluding COVID-19, each year in the U.S., and millions more suffer the health effects of those diseases, causing them to miss work to care for themselves or others and leaving them unable to engage in their routine activities. Data suggests that, prior to the COVID-19 pandemic, the economic burden of unvaccinated individuals was between $3.8 and $11.9 billion based on direct costs of care for vaccine-preventable diseases and productivity losses.[1] The COVID-19 pandemic has exacerbated this, causing adults to delay or avoid interactions with the health care system for preventive services. Elimination of cost sharing for ACIP recommended adult vaccines is a vital step to ensuring the health of Medicare Part D beneficiaries and the AAFP is pleased CMS has swiftly implemented these provisions.

While removing cost-sharing is an important step to increasing vaccination rates among adults, Part D-only coverage of certain adult vaccines still prevents patients from receiving vaccines during their annual check-up or other visit with their primary care physicians. Physicians continue to provide important vaccine counseling for patients but are then forced to send their patient to a pharmacy to receive their vaccine, as physicians cannot bill for Part D-covered vaccines. This hand-off often results in patients forgoing important vaccines when transportation, timing, or trust impede access to pharmacy-administered vaccines. **The AAFP looks forward to working with CMS and Congress to promote access to all ACIP-recommended vaccines from Medicare beneficiaries' usual source of continuous primary care.**

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

Additionally, managing prescription drug prices for patients is an important concern for family physicians. Family physicians regularly see patients who cannot afford their medications and thus cannot adhere to treatment recommendations. Patients affected by high prescription drug costs also are more likely to experience adverse health effects, including increased stress and anxiety, and may forgo other needs, such as transportation, utilities, housing, doctor's visits, or other medications, to afford their medications.[2] The AAFP strongly supported the IRA's provisions to cap cost-sharing for insulin at $35 per month for Medicare beneficiaries. More than 37 million Americans have diabetes, and an estimated one-quarter of people with diabetes in the U.S. ration their insulin due to costs.[3, 4] Unmanaged diabetes can lead to kidney damage, ICU hospitalization, and death.[5] In 2021, diabetes deaths exceeded 100,000 in the United States for the second consecutive year.[6] The AAFP applauds CMS for taking swift action to implement provisions capping prescription drug cost sharing for insulin and for beneficiaries in the catastrophic phase of coverage.

Universal Foundation for Quality Measurement

CMS recently announced a new initiative to promote the alignment of quality measures across public programs and help drive measure alignment across payers. CMS seeks comment on this initiative, known as the Universal Foundation for quality measures, and the measures CMS is considering including in the Universal Foundation.

The AAFP applauds CMS for its leadership and efforts to streamline quality and performance measures across its many programs. The AAFP has long advocated for the alignment of measures to reduce reporting burden and facilitate a more meaningful, effective measurement experience for physicians and patients. **The intention of the Universal Foundation is a step in the right direction toward reducing the burdens associated with the complex maze of measures and measurement processes that currently exist, but further work must be done to achieve meaningful, long-term improvement in the evolution of measurement.**

For the Universal Foundation to achieve its aims to alleviate the ongoing and intensifying challenges in measurement, including measure proliferation that leads to heavy administrative burden, it is imperative that CMS collaborate with private payers. We further urge CMS to work across health care stakeholders to promote a core measure set for primary care that focuses less on existing process measures and more on outcome measures, patient-reported measures, and more progressive measures that truly reflect the value of primary care.

For example, the AAFP has encouraged CMS to incorporate the Person-Centered Primary Care Measure (PCPCM) in the Merit-based Incentive Payment System (MIPS) and other appropriate programs. The PCPCM assesses the core elements of primary care, including the strength of the physician-patient relationship. Primary care requires a whole person approach, prioritization of needs, sophisticated primary care team, and consideration of the patient's goals within the context of their social system. The PCPCM assesses whether the patient's needs, goals, and social supports – the whole person – are being considered when providing care. The Continuity of Care Measure, endorsed for use through the National Quality Forum process in 2021 is another measure that should be included in a core set for primary care. The AAFP welcomes the opportunity to partner with CMS to strengthen the Universal Foundation to include measures that more effectively measure whole-person, longitudinal primary care.

Adult Immunization Status Measure

CMS seeks comment on the Adult Immunization Status HEDIS measure for use in the Universal Foundation. The AAFP is strongly supportive of efforts to increase utilization of safe and effective vaccines. We agree that the claims based HEDIS measure CMS plans to include in the Universal Foundation is appropriate for measuring MA organization performance. However, we have concerns about using similar composite adult vaccination measures to evaluate performance at the individual clinician or practice level.

The AAFP has expressed concern with the inclusion of the Adult Immunization Status measure in MIPS and other programs evaluating clinician performance without addressing related information sharing challenges first. As we have shared previously, current immunization registries and health data information sharing systems must first be fixed to more effectively aggregate patient information, including immunization records, to evaluate the quality of care reliably and accurately. This is particularly true for the influenza vaccine which is frequently received by patients in the community at grocery stores, pharmacies, workplaces, etc. Inadequate data aggregation and information sharing increases reporting burden, as physicians and their staff must manually track down and enter information for immunizations received outside their clinic. Despite their best efforts, there will undoubtedly be data gaps that will inappropriately be identified as care deficiencies under this measure. We encourage CMS to explore the use of their regulatory authority to address this long-standing gap in data aggregation and information sharing which results in unnecessary administrative time and burden placed on patients and physician practices. Until these changes are in place, we encourage CMS to prioritize measures that are supported by more efficient and accurate data sources and do not increase burden to physician practices for use in the Universal Foundation.

Social Needs Measure

CMS also indicates the agency plans to include the new Screening for Social Drivers of Health/ Social need Screening and Intervention HEDIS measure in the Universal Foundation. The AAFP provided comments on similar measures for accountable care organizations (ACOs) and Quality Payment Program participants in our response to the CY 2023 Medicare Physician Fee Schedule. Given that the Universal Foundation will be used across programs, we believe these comments are relevant both for measuring MA organizations' performance and clinician performance. We further note that these screenings and interventions typically happen in a physician office or other provider setting and therefore the onus of improving the measure score will ultimately fall on the physicians who contract with MA organizations. As such, it is important for CMS to consider how the addition of such measures could impact these clinicians.

The AAFP supports CMS' goal of reducing health inequities and believes MA organizations, family physicians, community-based organizations, along with others, play an important role in helping to identify and alleviate the health-related social needs of patients. We also agree that it is important for family and other primary care physicians to be connected to social and community-based organizations that can help to address those needs using an efficient, centralized approach. These are core tenants of comprehensive, longitudinal primary care, though we note that these types of services are often not billable when provided by physicians and other clinicians. Moving to alternative payment models (APMs) that include comprehensive prospective payment must be prioritized if we

are to sufficiently and sustainably support primary care's role in understanding and addressing patient's health related social needs. Further, **physicians and other clinicians cannot be held accountable for providing resources to address individual health-related social needs when those resources do not exist in the community.**

The overarching goal to drive improved health for historically marginalized and medically underserved populations cannot be achieved by any single stakeholder working in isolation. Addressing health equity and social drivers of health are community issues that require community solutions. Many communities simply do not have adequate social resources and community-based organizations available to help meet patients' diverse social needs. Even when those resources exist at the community level, community-based organizations are not typically resourced with the funding, skills, or staff to accept referrals from the health care system. **CMS should incentivize the development and use of community care hubs or other payer and provider agnostic centralized referral systems to ease the burden on all parties, including the community-based organizations best equipped to address patients' social needs.** MA organizations are well-positioned to help support the development and ongoing sustainability of community care hubs.

The AAFP is very supportive of screening for health-related social needs and has equipped its members with the tools to engage in this important aspect of whole-person care through the EveryONE Project. As screening patients for unmet health-related social needs is increasingly common for many provider types and at many entry points for patients into the health care and health insurance systems, there is increased interest in measurement of these efforts.

The AAFP agrees with CMS that social needs screening provides important patient and community level insights but urges caution when considering measurement of this activity as an indicator of care quality for an individual physician or in a single health care setting as doing so could lead to unnecessary, repetitive assessment efforts. The goal should be to build the infrastructure and capabilities necessary to securely share standardized patient-level social needs screening data across provider types in a timely fashion with the patient's permission to do so. This will ensure that all members of the patient care team are aware of their patient's unique needs while not overburdening physicians and their patients. These capabilities are not yet in place and moving too quickly could be detrimental to long-term progress. Overwhelming patients with different screening mechanisms at different points along their health care journey is likely to be frustrating to them and counter-productive to building trust with patients.

There are other challenges and important considerations to address before new social needs screening measures are introduced. Most importantly, the measure should address those factors or circumstances within the control of the individuals or organizations being measured. CMS' measurement strategy should account for these challenges and ensure performance measurement does not negatively impact underserved patients or the clinicians caring for them.

We noted in our comments on the CY 2023 MPFS that the AAFP does not support the introduction of the Screen Positive Rate for Social Drivers of Health as a measure of clinician or ACO performance as it does not reflect the quality of care delivered by family physicians or other clinicians. Rather, it reflects a variety of factors or circumstances beyond the control of the physician, such as the lack of resources in the community or patients not wanting assistance from available organizations. A high

"screen positive rate" indicates that the clinician cares for a high proportion of patients with unmet social needs and should not be disadvantaged in any quality or performance-based program.

Physicians and other clinicians should not be held accountable for these circumstances, which are beyond their control and doing so could worsen health inequities by discouraging clinicians and ACOs from working with under-resourced populations. Performance on this measure may be better suited for use in risk-adjustment methodologies or to help CMS understand which clinicians and ACOs are caring for underserved patient populations. We would support use of this measure for these purposes, including as a pay-for-reporting requirement. We again note that this measure should not be used to measure performance.

The AAFP again notes that the onus of MA organizations' performance on quality measures, and ultimately their Star Rating and related rate adjustment, is passed down to in-network physician practices. For example, an MA organization's primary care practices are conducting most of the screenings included in the Universal Foundation. Consistently high screening rates translate into positive measure performance and a high Star Rating. Despite the central role clinicians and practices play in achieving a high star rating, MA organizations are not required to provide additional support or resources to the in-network clinicians that help achieve these results, nor are they required to pass down the financial benefits of high performance. This is in conflict with the AAFP's policy which indicates individual physicians should share in the rewards that accrue from their performance. **We urge CMS to use its authority to better align the incentives and accountability in the MA program to ensure that physicians and practices receive investment and support from MA organizations to improve care, as well as financial benefits for successful performance.**

Changes to the Risk Adjustment Methodology

CMS risk adjusts capitated payments made to MA organizations using a hierarchical condition categories (HCCs) model and certain demographic factors (age/sex group, Medicaid status, disability status). Diagnosis codes are mapped to an HCC. CMS assigns relative factors for each demographic factor and HCC in the model and then estimates a dollar coefficient for each that represents the marginal cost of the condition or demographic factor in predicting per capita costs. CMS proposes to implement a revised version of the CMS-HCC risk adjustment model with several technical updates:

- An update to the time frame the HCC model is based on using Medicare fee-for-service (FFS) claims: 2018 claims for diagnoses and 2019 claims for expenditures;
- A clinical reclassification of the HCCs using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) codes; and
- A reclassification of diagnosis codes and condition categories based on a review of relative coding in MA versus FFS and clinical experts determining discretionary coding variation.

These proposed updates would result in over 2,000 ICD-10 diagnosis codes CMS believes should be removed from the CMS-HCC model, as well as significant changes to diabetes and congestive heart failure HCCs and the removal of three other HCCs.

The AAFP has long supported policies to protect and strengthen the Medicare program and therefore we support the intent of this proposal. We have also encouraged CMS to ensure risk-adjustment models are calibrated using updated data and designed to align with physicians' clinical practice.

CMS' proposals to update the data and denominator of the CMS-HCC model and reclassify the model to be based on ICD-10 diagnosis codes are therefore consistent with AAFP advocacy.

The AAFP believes the accuracy of data used for risk adjustment purposes is paramount and that the physicians and other clinicians who serve as the patient's usual source of continuous primary care are best positioned to provide these data. Third-party assessments or encounters designed solely to identify patient risk factors do not serve the best interest of the patient as they focus on identifying illness over treating it and are potentially disruptive to established patient physician relationships. **CMS should consider additional guardrails to prevent the use of such third-party assessments.**

The AAFP urges CMS to ensure that the implementation of these updates to the CMS-HCC model does not result in negative impacts on MA enrollees or the physicians who care for them, including by delaying or extending the implementation timeline for the updates if needed. While CMS' analysis may provide a general understanding of the impacts at a program level, each MA organization will need additional time to understand how these changes will impact them, including how to thoughtfully address potential revenue shortfalls or other challenges. Given that the downstream impact of these proposed changes on MA enrollees and physicians is unclear, full implementation in 2024 could result in unintended consequences. Delaying implementation or using a blended implementation approach over a number of years, would allow CMS to evaluate how risk-adjustment updates may impact beneficiaries' care and step in to address potential problems. In proposing these changes to ensure that payments made to MA organizations accurately reflect the health status and anticipated cost of providing coverage for their MA enrollees, CMS must also ensure that actions MA organizations take in response to these updates do not create unintended consequences that could disrupt patient care. This is especially important when considering that MA enrollees have lower incomes and a higher proportion of racial and ethnic minorities when compared to traditional Medicare.[7] The AAFP would support a delayed or extended implementation of the CMS-HCC model changes if needed to prevent unintended consequences falling on patients and physicians.

We further recommend CMS consider additional guardrails to prevent MA organizations from passing potential revenue reductions onto the physician practices they contract with and ensure MA organizations are using Medicare payments to invest in and support the provision of high-quality primary care. Primary care services are comprehensive, longitudinal, person-centered, and delivered within the context of a patient's community. Promoting access to continuous primary care improves individual patient and population-level outcomes, reduces health care expenditures, and advances health equity.[8,9,10,11,12]

Primary care practices continue to struggle with inadequate physician payment rates, staffing shortages, and overwhelming administrative burden. Additional payment cuts, costly system updates, and other downstream effects of these changes could further destabilize the primary care practices Medicare beneficiaries depend on. CMS should use its monitoring and oversight authority to ensure these practices do not bear the brunt of these changes and have sufficient time to adjust.

The ideal payment system for primary care is aligned across payers and provides predictable, prospective revenue streams as a foundation to sufficiently support this high-value care in addition to performance incentives that reward improvement (and sustained positive performance) against financial and quality benchmarks. Within practices and other health care organizations, individual physicians should share in the financial rewards that accrue from their performance. Finally, such value-based payments should constitute an increased investment in primary care and be risk-adjusted to accurately represent patients' clinical, demographic, and other relevant risk factors including unmet social needs. The AAFP advocates for value-based primary care payments that align with these principals because they provide practices with the support and flexibility they need to improve patient care.

The AAFP has advocated to accelerate the adoption of primary care alternative payment models across payers, including in MA. The use of these models in MA better aligns financial incentives with improving patient care. Survey data from the Health Care Payment Learning & Action Network indicates the adoption of APMs in MA is increasing. **We urge CMS to continue promoting the adoption of value-based prospective primary care payment models in MA as one key strategy to insulate and strengthen primary care as the agency makes important changes to protect the MA program.**

The AAFP notes that existing alternative payment models, including the Medicare Shared Savings Program, Primary Care First, and ACO REACH also use HCC scoring to risk-adjust benchmarks and/or payments to primary care. While the proposed modifications to the CMS-HCC model in the MA program are used to determine payments to MA organizations and should not directly impact payment for most primary care physicians, if these modifications are applied in a similar fashion in other programs, primary care payment (and thus, patient care) could be more directly impacted.

Accurately accounting for all factors that influence an individual's health status is particularly important when determining primary care payment given that primary care physicians assess and treat patient conditions in the context of their co-occurring conditions, medical history, and other factors like social and economic circumstances. We urge the Center for Medicare and CMMI to work together, and in collaboration with other key stakeholders, to better understand the potential impact on physicians and determine if these HCC risk-adjustment modifications should be applied to current or future alternative payment models that center on primary care.

Thank you for the opportunity to provide comments on the 2024 MA Advanced Notice. The AAFP looks forward to continuing to partner with CMS to advance equitable access to high-quality, comprehensive primary care for all. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org or (202) 235-5136.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

[1] Sachiko Ozawa, Allison Portnoy, Hiwote Getaneh, Samantha Clark, Maria Knoll, David Bishai, H. Keri Yang, and Pallavi D. Patwardhan. Modeling The Economic Burden Of Adult Vaccine-Preventable Diseases In The United States. Health Affairs 2016 35:11, 2124-2132. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0462

[2] The Endocrine Society. (2021, January 12). Addressing Insulin Access and Affordability: An Endocrine Society Position Statement. The Endocrine Society . Retrieved July 29, 2022, from https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/insulin-position-statement-jcem.pdf

[3] Centers for Disease Control and Prevention. (2022, January 24). The facts, stats, and impacts of diabetes. Centers for Disease Control and Prevention. Retrieved July 29, 2022, from https://www.cdc.gov/diabetes/library/spotlights/diabetesfacts-stats.html#:~:text=37.3%20million%20Americans%E2%80%94about%201,t%20know%20they%20have%20it

[4] Silverman, E. (2019, October 20). One-quarter of people with diabetes in the U.S. are rationing their insulin. STAT News. Retrieved July 29, 2022, from https://www.statnews.com/pharmalot/2019/06/18/one-quarter-of-people-with-diabetes-in-theu-s-are-rationing-their-insulin/

[5] Endocrine Society. (2022, June 21). Endocrinologists Share Patient Stores on Access to Affordable Insulin. Endocrine Society. Retrieved July 29, 2022, from https://www.endocrine.org/news-and-advocacy/news-room/2022/endocrine-societysclinical-practice-guideline-offers-recommendations

[6] Romaine, J. (2022, January 31). Diabetes deaths exceed 100K in US for second straight year. The Hill. Retrieved July 29, 2022, from https://thehill.com/changing-america/well-being/prevention-cures/592114-diabetes-deaths-exceed-100000-in-usfor-second/

[7] Teigland C, et al. As It Grows, Medicare Advantage Is Enrolling More Low-Income and Medically Complex Beneficiaries. The Commonwealth Fund. May 13, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/may/medicare-advantage-enrolling-low-income-medically-complex

[8] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.

[9] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Intern Med. 2019 Apr 1;179(4):506-514. doi: 10.1001/jamainternmed.2018.7624. PMID: 30776056; PMCID: PMC6450307.

[10] Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. Br J Gen Pract. 2020 Aug 27;70(698):e600-e611. doi: 10.3399/bjgp20X712289. PMID: 32784220; PMCID: PMC7425204.

[11] Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL Jr. Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations. Ann Fam Med. 2018 Nov;16(6):492-497. doi: 10.1370/afm.2308. PMID: 30420363; PMCID: PMC6231930.

[12] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.