



July 12, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write in response to the final rule with comment period titled “Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards” published in the [Federal Register](#) on April 14, 2022.

CMS has requested comments on section III of the final rule, “Request for Comment Regarding the Methodology for CMS to Update and Change Service Category Cost Sharing.” Specifically, section III addresses reducing discriminatory cost sharing by implementing limits for certain service categories and increasing transparency by adding parameters to update copayment limits after cost sharing limits are implemented.

Summary

CMS annually sets cost sharing limits for Medicare Advantage (MA) plans. CMS notes in the rule that MA organizations typically offer benefits with lower cost sharing amounts than the cost sharing limits CMS has used in the past. However, CMS is concerned about benefit designs that have in-network cost sharing at the highest allowable level for a subset of benefits, including mental health services, even if the MA plans use lower cost sharing for other benefits or categories of services. As a result, CMS is soliciting recommendations regarding the service categories for which CMS should consider modifying cost sharing limits (including specific cost sharing limits changes) to ensure beneficiaries are protected from potentially discriminatory cost sharing. The goal of these modifications would be to prohibit cost sharing amounts for those service categories that exceed cost sharing in original Medicare.

In this final rule with comment period (FC), CMS solicits comments on the necessity, appropriateness, and feasibility of preventing copayment limits from changing dramatically or fluctuating from year to year. CMS seeks further comments on how to protect beneficiaries from excessive cost sharing, as well as how CMS can limit the costs MA beneficiaries experience when accessing their health benefits.

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AAFP Response

The AAFP appreciates that CMS is examining MA benefit designs to protect Medicare beneficiaries from potentially discriminatory cost sharing. We especially appreciate that CMS has called out mental health services in this regard. The AAFP [supports parity](#) of health insurance coverage for patients, regardless of medical or mental health diagnosis. Health care plans, including MA plans, should cover mental health care under the same terms and conditions as that provided for other medical care. This includes cost-sharing and non-quantitative treatment limits (NQTLs) like prior authorization and step therapy. **To this end, we urge CMS to establish MA cost sharing limits for mental health services, including substance use disorder (SUD) treatment to ensure beneficiary cost sharing for such services is on par with cost sharing for medical services, and that mental health services are not subject to additional NQTLs.**

The President's FY 2023 budget and Unity Agenda both direct more resources to improving access to mental health and SUD care. The AAFP [supports](#) this goal and urges CMS to advance it by removing cost-sharing and other barriers MA beneficiaries face in accessing mental health services. Additionally, behavioral health integration in primary care settings has shown cost savings for patients and payers and increased access to mental health care for patients. Bolstering primary care resources is essential to improving care access for the 139 million Americans living in mental health professional shortage areas as well as for Black and Hispanic individuals less likely than white individuals to receive care for mental illness. CMS should ensure MA plans provide coverage and adequate payment for integrated behavioral health services provided by primary care physicians, as well as services provided by other licensed behavioral health professionals in the primary care setting.

CMS seeks comments on how the agency could remove cost barriers to other high-value services. The AAFP also encourages CMS to minimize or eliminate out-of-pocket costs for high-value primary care services in defined patient populations to improve access to and utilization of these essential services. Primary care services are proven, high-value health care services, that improve health outcomes and decrease costs.^{i, ii} In the U.S., an increase of one PCP per 10,000 people found a decrease in both infant and adult mortality and a 3.2 percent reduction in low birth weight.^{iii, iv} States with higher ratios of PCPs have lower smoking rates, lower obesity rates, and higher seatbelt use compared to states with lower ratios of PCPs.^{v, vi} Further, Medicaid-enrolled children who have access to high-quality, timely, family-centered primary care have experienced both lower nonurgent and urgent emergency department utilization rates.^{vii} Health care systems that prioritize primary care have lower health care costs, including decreases in costly hospitalizations and emergency department visits.^{viii} By contrast, a survey of 11 developed countries, including the U.S., found that patients with poorer levels of primary care were notably more likely to report higher out of pocket expenses, increased emergency room use in the past two years, greater physician turnover, and a lower likelihood of patients receiving critical immunizations or screenings, such as those for high blood pressure or cholesterol.^{ix}

Removing cost sharing for primary care services increases access to these services and reduces emergency department and other outpatient visits without increasing overall health care spending.^x Taken together, the available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. The AAFP urges CMS to use its authority to reduce or remove cost-sharing for primary care.

Additionally, we note that it is CMS's [stated goal](#) to have 100 percent of Medicare beneficiaries in an accountable relationship by 2030. Given the accountable relationship for most beneficiaries would be with primary care, eliminating cost-sharing for those services would help CMS achieve its aim. Ideally, CMS would do that under Medicare Advantage by setting the cost sharing limits for primary care services at zero. To the extent CMS can effectuate that in Medicare Advantage, affected beneficiaries would benefit.

To the issue of preventing copayment limits from changing dramatically or fluctuating from year to year, **we believe it would be appropriate and helpful for CMS to limit copayment fluctuations from both a patient and physician practice perspective.** Many Medicare beneficiaries, especially vulnerable populations with higher-cost health care conditions, are on fixed incomes. Copayments and other forms of cost sharing act as a deterrent to seeking often necessary care for such individuals. Copayments that change dramatically or fluctuate substantially from year to year only serve to increase that deterrence when beneficiary income is fixed. Stable cost-sharing better allows many Medicare beneficiaries to budget necessary health expenditures.

Likewise, many family medicine practices operate on thin margins with tenuous revenue streams tied to fee-for-service. The current public health emergency has demonstrated how tenuous those revenue streams are. To the extent patient cost sharing is part of that revenue stream, its predictability and stability becomes important for business planning purposes and in terms of financial viability. Thus, preventing copayment limits and the cost sharing they represent from fluctuating dramatically from year to year is one way in which CMS can help support family medicine and other primary care practices. Supporting independent primary care practices prevents consolidation, which ultimately prevents price increases and maintains beneficiaries' access to high-quality, affordable primary care in their own communities.

Thank you for the opportunity to provide comments on this final rule. Should you have any questions or wish to schedule a meeting, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive, flowing style.

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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- ⁱ National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.
- ⁱⁱ James Macinko, Frederico C. Guanais, Population experiences of primary care in 11 Organization for Economic Cooperation and Development countries, *International Journal for Quality in Health Care*, Volume 27, Issue 6, December 2015, Pages 443–450, <https://doi.org/10.1093/intqhc/mzv074>
- ⁱⁱⁱ Shi L, Mackino J, Starfield B, Xu J, Regan J, Politzer R, Wulu J. (2004). "Primary care, infant mortality, and low birth weight in the states of the USA." *J Epidemiol Community Health*. Web.
- ^{iv} Machinko J, Starfield B, Shi L. (2007). "Quantifying the health benefits of primary care physician supply in the United States. *International Journal of Health Services*. Web
- ^v Ibid.
- ^{vi} Gaglioti AH, Petterson S, Bazemore A, Phillips R. (2016). "Access to primary care in US counties is associated with lower obesity rates." *J Am Board Fam Med*. Web.
- ^{vii} Brousseau DC, Gorelick MH, Hoffman RG, Flores G, Nattinger AB. (2009). "Primary care quality and subsequent emergency department utilization for children in Wisconsin Medicaid." *Acad Pediatr*. Web.
- ^{viii} Leiyu S. (2012). "The Impact of Primary Care: A Focused Review." *Scientifica*. Web.
- ^{ix} James Macinko, Frederico C. Guanais, Population experiences of primary care in 11 Organization for Economic Cooperation and Development countries, *International Journal for Quality in Health Care*, Volume 27, Issue 6, December 2015, Pages 443–450, <https://doi.org/10.1093/intqhc/mzv074>
- ^x Ma, Q. Sywestrzak, G. Oza, M. Garneau, L. DeVries, A. "Evaluation of Value-Based Insurance Design for Primary Care." (2019). *The American Journal of Managed Care*. 25: 5. <https://www.ajmc.com/view/evaluation-of-valuebased-insurance-design-for-primary-care>