



January 16, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS Proposes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-P)

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Changes and Updates for Medicare Advantage (MA) and the Prescription Drug Benefit Program (Part D). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College has long identified how the growing number of administrative tasks imposed on physicians adds unnecessary costs to the U.S. health care system and diverts time and focus from patient care. We have strongly advocated for reducing these administrative tasks and putting patients first through our ongoing Patients Before Paperwork¹ initiative and the development of significant policy recommendations² for reducing administrative burden throughout the health care industry, including a recent policy paper focused on transparency

¹ <https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork>

² <http://annals.org/aim/fullarticle/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>

and alignment within MA.³ ACP is encouraged that CMS is soliciting comments on how to reduce burden for physicians participating in the MA program and appreciates the opportunity to provide specific feedback on burden reduction as well as other relevant provisions in the proposed rule.

Reducing Burden of Medical Record Requests

CMS adjusts payments to MA organizations based on the various risk factors of their beneficiary population and requires MA plans to submit data supporting and characterizing the services provided to their beneficiaries, including diagnosis codes, to accurately calculate these risk-adjusted payments. In order to meet these requirements, MA plans include in their contracts with participating physicians provisions that require physicians to submit complete and accurate risk adjustment data – with some contracts including financial penalties for failure to provide the requested data.

These medical record requests by MAOs are burdensome to physicians due to the additional unpaid time and practice resources required by either the physician or staff to collect and submit this information to the MAO. Many times there are duplicative requests for records and wasted time determining if the request has already been fulfilled – all of which takes away from time spent with the patient. These issues are even more burdensome for small or solo practices that have less staff to process such requests. Not only is the process burdensome for the physician, it lacks transparency when it comes to the physician having access to all of the relevant diagnoses for specific patients. For example, primary care physicians are sometimes unaware of diagnoses made by specialists due to the lack of interoperability between electronic health record (EHR) systems. **In order to reduce the burden and make the medical record request process more transparent, ACP recommends that CMS require MAOs to simplify the data submission process and allow for electronic submission, if possible, as well as require MAOs to provide access to the full set of diagnoses attributed by all of the patient’s clinicians in a clear and understandable format.**

Recent ACP policy⁴ calls for transparency within the MA program – including among participating physicians, payers, pharmacy benefit managers (PBMs), and Part D sponsors. Reworking the medical record request process provides CMS with an opportunity to promote transparency through providing access to the entirety of claims data used to risk adjust payments in the MA program. Moreover, as practices are transitioning into the Quality Payment Program (QPP) and attempting to participate in advanced alternative payment models (APMs), knowledge and access to these critical diagnoses will become even more important for the primary care physician to correct any inaccurate diagnoses, remove those diagnoses that have been resolved, and provide the full set of appropriate diagnoses to increase acuity and accurately calculate risk for payment adjustments.

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https://www.acponline.org/acp_policy/policies/promoting_transparency_and_alignment_in_medicare_advantage_2017.pdf

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https://www.acponline.org/acp_policy/policies/promoting_transparency_and_alignment_in_medicare_advantage_2017.pdf

Inclusion of Fraud Prevention and Medication Management Therapy in Medical Loss Ratio (MLR) Calculation

Since 2014, all MAOs and Part D sponsors have been required to submit their medical loss ratio (MLR) data to CMS. The MLR represents the percentage of the plan's revenue used for patient care rather than administrative costs or profit. MA plans are subject to financial or other penalties if they do not reach an MLR of at least 85 percent. CMS proposes updates to the numerator (the sum of all amounts reported as claims or as health care quality improvement expenses) in the MLR equation to include fraud prevention activities (e.g., fraud prevention, fraud detection, and fraud recovery) and medication management therapy (MMT).

ACP disagrees with the inclusion of fraud prevention activities in the numerator of the MLR calculation. Fraud prevention activities are the cost of doing business and the MAO's responsibility; these activities are not part of the actual cost of taking care of the patient. The underlying policy rationale for the MLR was to make sure that taxpayer money would be used for treatment of medical conditions and not go towards the administration of the plan or profits for the insurers. Adding these types of activities into the MLR numerator does not align with the intent of MLR and opens the door for other types of administrative activities to be added into the calculation. Additionally, fraud prevention is an administrative undertaking that itself creates significant burdens on participating physicians and practices. ACP is concerned that the inclusion of these activities in the MLR calculation provides an incentive for MA plans to institute more aggressive and burdensome antifraud activities that inevitably fall on physicians, other health care clinicians, and their staff. **Therefore, ACP does not support the inclusion of fraud prevention activities in the numerator of the MLR and recommends CMS not adopt this proposal.**

As for the inclusion of MMT in the MLR numerator, the College has concerns that this could also create administrative burden for the physician as well as medication denials and delays for patients. **ACP recommends CMS ensure that any MMT required by the MAO does not place any undue administrative burden on the prescribing physician or excessive and unnecessary delays or denials for patients.**

CARA Implementation and Case Management Requirements

ACP strongly supported the Comprehensive Addiction and Recovery Act (CARA) and has offered recommendations regarding prescription drug use and treatment of substance use disorders.^{5,6} The College believes physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. **ACP strongly believes that physicians must become familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic intervention.**

⁵ <http://annals.org/aim/fullarticle/2613555/health-public-policy-facilitate-effective-prevention-treatment-substance-use-disorders>

⁶ <http://annals.org/aim/fullarticle/1788221/prescription-drug-abuse-executive-summary-policy-position-paper-from-american>

ACP also offered input on the Center for Disease Control and Prevention's (CDC) Guideline for Prescribing Opioids for Chronic Pain. The CDC's guideline helps inform physicians of when opioids are appropriate for a typical patient with chronic pain; however, patients have individual care needs that may not reflect the recommendations presented in the guidelines. In our recommendations to the CDC, we expressed concern that insurers would use the CDC guidelines in a manner that would inappropriately decrease access to opioid medications for individuals for whom they serve as the most effective means of addressing pain and increasing functionality.⁷ We are concerned that the proposal uses the morphine milligram equivalents dosage described in the CDC guideline as a relevant factor in determining that opioids are frequently abused or diverted and may potentially trigger case management and other activities. **Therefore, ACP cautions that such thresholds should not be rigidly applied and there must be some flexibility to allow adjustments in determining dosages reflecting physician judgment.**

Any attempts to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature and which undergo review and approval of associated Part D plan's Pharmacy and Therapeutics (P&T) committee. We are concerned that the case management process described in the proposed rule could stall patient access to medically necessary pain medication and create new administrative burdens for prescribers. The College recognizes the intent to prevent patients from seeking prescriptions from multiple prescribers or pharmacies, but this additional process may prove redundant with the availability of prescription drug monitoring programs designed to address this problem. We concur with the need to be judicious in contacting prescribers and support seamless communication and efforts to reduce unnecessary tasks on prescribers and encourage amending 423.153(f)(2) to read "The sponsor's clinical staff must conduct, *in a manner that does not place an undue administrative burden on prescribers*, case management for each potential at-risk beneficiary for the purpose of engaging in clinical contact with the prescribers of frequently abused drugs and verifying whether a potential at-risk beneficiary is an at-risk beneficiary."

Default Enrollment into MA or "Seamless Conversion"

After issuing a moratorium on the "seamless conversion" process in which newly eligible Medicare beneficiaries are automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out, CMS now proposes to establish strict limits and requirements for automatic enrollments. Specifically, CMS will only allow "seamless conversion" for individuals remaining in a Medicaid managed care plan offered by the same parent organization offering the MA plan as long as the plan meets five requirements, including that the MA plan provide notification to the individual that meets the requirements for "seamless conversion." **ACP has called for transparency in the MA program⁸ at both the physician and consumer level and appreciates that CMS has re-evaluated the**

⁷ https://www.acponline.org/acp_policy/letters/acp_comments_draft_guidelines_opioids_2016.pdf

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https://www.acponline.org/acp_policy/policies/promoting_transparency_and_alignment_in_medicare_advantage_2017.pdf

“seamless conversion” process and outlined stricter guidelines for MA plans that choose to automatically enroll their Medicaid managed care beneficiaries. ACP urges CMS to continue to promote transparency and ensure MA plans communicate to eligible beneficiaries about the automatic enrollment in a timely and understandable manner.

Prescription Drug Plan Updates

The College appreciates CMS’ effort to address the burden of high prescription drug costs on patients and their families by proposing numerous changes to the Medicare Part D Prescription Drug Benefit Program. ACP strongly encourages CMS to review our policy paper *Stemming the Escalating Cost of Prescription Drugs: A Position Paper of the American College of Physicians* for recommendations aimed at creating greater transparency in the pricing of prescription drugs; increasing competition in the marketplace; and ensuring affordability and accessibility of prescription drugs to all beneficiaries.

Conclusion

ACP appreciates the opportunity to provide feedback to CMS on the MA and Prescription Drug Program and is encouraged that the Agency is focused on burden reduction for physicians and lowering the cost of high-priced prescription drugs for Medicare beneficiaries. We look forward to continuing to work with CMS on addressing these important issues which we believe will lead to improved patient care and outcomes as well as reduce health care costs. Thank you for considering our comments. Please contact Brian Outland, PhD, Director of Regulatory Affairs, by phone at 202-261-4544 or e-mail at boutland@acponline.org if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP
Chair, Medical Practice and Quality Committee
American College of Physicians