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March 1, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-2018-0154
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Dear Administrator Verma:

On behalf of the over 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) *Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter*, published in the *Federal Register* on January 30, 2019.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of surgical care is paid for under Part C and surgical patients often access their prescription drugs via Part D, the College has an interest in these programs and CMS' efforts to reduce costs for Medicare beneficiaries, and we believe that we can offer insight to the Agency's modifications to such policies. Our comments below are presented in the order in which they appear in the advance notice and draft call letter.

2020 ADVANCE NOTICE

Attachment II – Changes in the Part C Payment Methodology for CY 2020

Section J – Frailty Adjustment for PACE Organizations and FIDE SNPs

Section 1853(a)(1)(B)(iv) of the Social Security Act allows CMS to make a payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs) if the average level of frailty in the FIDE SNP is similar to the Program of All-Inclusive Care for the Elderly (PACE). The Agency currently estimates frailty factors to explain additional costs not explained by diagnoses in the CMS-Hierarchical Condition Category (HCC) model and calibrates such factors by regressing unexplained costs from the CMS-HCC risk adjustment model on counts of activities of daily living (ADLs).

For CY 2020, CMS proposes to utilize updated frailty factors based on the Payment Condition Count (PCC) model, rather than the CMS-HCC model, when calculating FIDE SNP frailty scores. Under this proposed PCC-based frailty adjustment, CMS would blend 50 percent of the frailty score calculated from the PCC model frailty factors with 50 percent of the frailty score calculated from the CMS-HCC model frailty factors. The Agency would then compare this blended frailty score with that calculated using only the CMS-HCC model for the PACE level of frailty to determine whether the two programs have a similar average frailty level.

Table 1. Frailty Factors based on the Proposed PCC model

ADL	Non-Medicaid	Medicaid
0	-0.078	-0.141
1-2	0.161	0.021
3-4	0.303	0.151
5-6	0.303	0.371

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Table 2. Frailty Factors based on the 2017 CMS-HCC Model

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

The ACS believes that it is unlikely that the average frailty score and overall care costs for dual-eligible beneficiaries would be less than such amounts for baseline Medicare-only patients, and we question why FIDE SNPs would receive a higher negative payment adjustment for ADL level 0—particularly under the proposed PCC Model—and lower positive payment adjustments for ADL levels 1-4 relative to the PACE program based on the frailty factors under both models. **The College asks that CMS clarify how the Agency validated the blended frailty score under the proposed PCC Model to ensure the integrity of its calculations and an accurate depiction of the true cost of care for FIDE SNP enrollees.**

DRAFT CY 2020 CALL LETTER

Section I – Parts C and D

Enhancements to the 2020 Star Ratings and Future Measurement Concepts

Each year, CMS calculates Parts C and D Star Ratings to assess the quality of Medicare Advantage Organizations (MAOs) and Part D plan sponsors and to determine related bonus payments. The Agency annually reviews the measures and methodologies used to generate Star Ratings to provide an accurate reflection of plan performance in five broad categories: (1) outcomes [i.e., improvements in a beneficiary's health status], (2) intermediate outcomes [i.e., actions taken to assist in improving a beneficiary's health status, such as controlling blood pressure for a patient with hypertension], (3) patient experience [i.e., beneficiaries' perspectives of the care they received], (4) access [i.e., processes and issues that could create barriers to receiving needed care, such as the time it takes for a plan to make a decision about an appeal], and (5) process [i.e., services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status].

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Plans are scored on individual measures in each of these categories using a five-star rating system and are then assigned an overall score based on the average of the ratings across all measures.

CMS seeks feedback on possible future measure updates and concepts to enhance the Star Ratings program. **The ACS wishes to reiterate our strong concern with the extensive prior authorization (PA) processes currently imposed by MAOs and urges the Agency to create Star Ratings measures to analyze MA plans' performance in conducting PA reviews of medical services.** PA places an extraordinary administrative burden on physicians and their practices, and we believe that payors, including MAOs, routinely use PA to deter clinicians from ordering or furnishing medically-necessary care rather than as a legitimate mechanism for identifying overutilization. **We do not believe that CMS can fully quantify the quality of a plan and its enrollees' experiences if PA—the negative effects of which impact multiple aspects of care provision and plan performance can be seen in each of the five Star Ratings plan performance categories—is not adequately reviewed and regulated by the Agency.**

In the CY 2018 *Advance Notice and Draft Call Letter*, CMS discussed adopting a new display measure under which the Agency would publish the percentage of claims inappropriately rejected by each Part D plan sponsor due to PA or other utilization management tools; CMS noted that such a measure could be proposed as an "access" star rating by 2020 at the earliest.[1] **We ask that the Agency subject MAOs to the same scrutiny as Part D plans regarding their PA use and encourage CMS to propose display measures that address MA plan PA processes—such as automation of PA, adoption of the standard PA transaction (Attachment Standard 278), timeliness of pre-service organization determinations, rate of denied PA requests, and accessibility of the plan's list of services that require PA in order for such services to be covered—for testing and future inclusion in the Star Ratings program.**

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[1] Centers for Medicare & Medicaid Services. (2017). *Advance notice of methodological changes for calendar year (CY) 2018 for Medicare Advantage (MA) capitation rates, Part C and Part D payment policies and 2018 call letter*. Retrieved from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf

Section II – Part C

Provider Directories

CMS states in this draft call letter that it recently concluded the third year of online provider directory reviews and observed a lack of improvement in the accuracy of provider directories over the past three years. The Agency also notes that the current process of verifying the accuracy of provider information presents an undue burden on providers, as multiple plans, in an effort to validate their directory information, ask providers the same validation questions. **The ACS believes it is imperative that insurance plan network listings are up-to-date, correct, and easy for patients to access, and we encourage CMS to renew its focus on improving provider directory accuracy**. Efforts to address coverage issues related to whether providers are in- or out-of-network will only be successful if there is sufficient transparency and accessibility of information as to a provider's network status.

Interoperability and Prior Authorization Coordination

In this draft call letter, CMS encourages all payors, including MAOs and Part D sponsors, to align their interoperability efforts and PA processes with recommendations made under the Da Vinci Project, an industry-led initiative to identify and implement care delivery use cases for the exchange of information between health plans and providers. The Agency notes that, in support of the Da Vinci Project, it began developing a prototype Medicare Fee-for-Service (FFS) Documentation Requirement Lookup Service (DRLS), which would digitally utilize the information inserted by a physician into their electronic health record (EHR) for a specific Medicare FFS beneficiary to determine what (if any) documentation or PA requirements might impact clinical decision-making or coverage for that patient; if the DRLS identifies any such requirements, it will automatically respond to the physician through their EHR with the appropriate documentation or PA policies as well as any related templates the physician should complete and include to CMS in their claims submission.[2] The Agency recommends that payors develop a similar lookup service

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[2] Centers for Medicare & Medicaid Services. (2018). *Special Open Door Forum: Documentation Requirement Lookup Service.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Other-Content-Types/Documentation-Requirement-Lookup-Service-Special-Open-Door-Forum-Slides-Oct-23.pdf

and populate the tool with their documentation rules and list of items and services for which PA is required.

The ACS supports CMS' message to payors and agrees that the documentation and PA requirements associated with coverage and reimbursement for clinical services and supplies should be made available by health plans in EHRs at the point of care to provide physicians with the real-time information they need when making treatment decisions. We believe that patient and payor data should be leveraged in EHRs to notify physicians of PA and other documentation requirements when ordering a service, automate PA decisions for routine therapies, and pre-populate PA forms for cases in which further review is needed. The use of information already stored in EHRs and the digital environment more broadly to complete such processes could streamline payor-provider communication, improve the accuracy and efficiency of these non-clinical tasks, and ensure the timely provision of care. We note, however, that the reduction of burden associated with such lookup services could be diminished by the potential existence of a large number of vendors providing these services.

The College commends CMS' focus on promoting interoperability, but we also ask that the Agency address the numerous non-digital process flaws associated with PA. We urge CMS to focus its MAO oversight and audit activities on the extent of PA requirements imposed by plans and by establishing policies that (1) limit the scope of MAOs' PA requirements to physicians whose ordering practices stray from evidence-based medicine or suggest a pattern of overutilization; (2) prohibit MAOs from applying PA to services that are standard for a specific condition, are part of an ongoing therapy regimen, exhibit low variation in utilization or denial rates, or have been approved previously as part of a patient's care plan; and (3) eliminate trivial barriers to payment in order to guarantee coverage and reimbursement from MAOs for a service performed that is clinically comparable to an approved service but is more accurately reported using a different current procedural terminology (CPT) code, or when a particular service's necessity was not anticipated and/or the service was performed incident to, or during the course of, an approved procedure.

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Section III – Part D

Improving Access to Opioid-Reversal Agents

Naloxone Co-Prescribing

In this draft call letter, CMS recommends that clinicians co-prescribe naloxone with opioid prescriptions for patients who are at an increased risk for opioid overdose. The Agency encourages Part D plan sponsors to ensure authorizations are in place to allow for naloxone co-prescribing for beneficiaries who are more susceptible to opioid-associated harm (e.g., claims history of ≥ 50 morphine milligram equivalents per day, concurrent benzodiazepine use). CMS also recommends targeted education of prescribers and patients on the co-prescribing of naloxone to prevent accidental overdoses and to appropriately address the needs of patients with opioid use disorders.

The ACS does not believe that it is appropriate for CMS to broadly encourage the co-prescribing of naloxone with opioids, and suggests that the Agency instead strengthen its processes to facilitate drug co-management between surgeons, primary care providers, pain medicine physicians, and other specialists when identifying and treating high-risk patients. We wish to remind CMS that clinicians do not prescribe opioids to such a level that misuse or overdose is expected, and we question if the Agency has considered the potential medical liability and malpractice implications associated with naloxone co-prescribing should a clinician be perceived to have willfully prescribed opioids to a patient with the knowledge that the patient was at-risk or had been previously diagnosed with an opioid use disorder. While the College opposes the commonplace prescribing of naloxone with opioids, we are supportive of CMS' general efforts to reduce the high out-of-pocket costs for opioid-reversal agents in order to remove barriers to patients' access to naloxone products during an overdose event.

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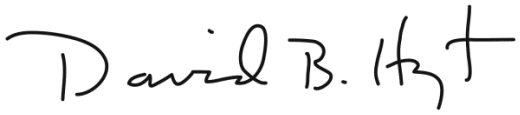
The ACS appreciates the opportunity to provide feedback on this advanced notice and draft comment letter, and we look forward to continuing dialogue with CMS on the Medicare Parts C and D programs. If you have any questions about our comments, please contact Vinita Ollapally, Regulatory Affairs Manager, at vollapally@facs.org.

Sincerely,



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