

January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-8013

Re: CMS-4182-P

Re: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

Dear Administrator Verma:

On behalf of more than 37,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the draft rule for the Medicare Advantage program and the Part D Prescription Drug Benefit Program as they affect our practice of emergency medicine and the patients we serve.

As CMS revises these programs to make improvements and implement provisions of the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, we offer the following comments.

Medicare Part D Drug Management Programs

In accordance with Section 704(g)(3) of CARA and revised section 1860D-4(c) of the Social Security Act, CMS is establishing a framework under which Part D plan sponsors may establish a drug management program for beneficiaries at risk for prescription drug abuse or misuse. In doing so, sponsors may limit at-risk beneficiaries' access to coverage of CMS-determined "frequently abused drugs" to a selected prescriber(s) and/or network pharmacy(ies).

ACEP appreciates the urgency of addressing our nation's growing opioid crisis, as our members see its impact every day as they work in emergency departments on the front lines of this epidemic all across the country. We therefore supported the provisions in the CARA legislation creating pharmacy/physician "lock in" programs that also ensured appropriate access to needed medications for beneficiaries receiving emergency medical care.

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As such, ACEP largely supports CMS' proposed regulatory framework for Part D plan sponsors to voluntarily adopt drug management programs through which they can address potential overutilization of frequently abused drugs by identifying potential at-risk beneficiaries, conducting case management, and (if necessary) limiting access to coverage for such drugs through pharmacy or prescriber lock-in, as well as beneficiary-specific point-of-sale claim edit.

Unlike many other specialties, emergency physicians generally do not have an existing relationship with their patient, and therefore may have only limited access to information that can be useful in identifying those potentially at risk for misuse or abuse of controlled substances. By providing plan sponsors with a uniform framework to implement drug management programs, this proposal can help to mitigate uncertainty around prescribing opioids and ensure consistency across sponsors.

Yet ensuring patients can continue to have access to needed medication when having received emergency medical care is paramount. Therefore, we are pleased to see that the CMS proposal directly implements the requirements laid out in CARA for the sponsor to first conduct case management, including clinical contact, before coverage of any frequently abused drugs can be restricted. This can help ensure that any limitations are clinically appropriate and that beneficiaries can be ensured sufficient notice that coverage may be restricted.

As well, CMS proposes to allow beneficiaries deemed at risk to submit preferences for approved prescriber(s) and/or pharmacy(ies). This too is directly in line with the CARA provision. We seek further clarification, though, of the proposed implementation of the CARA requirements surrounding reasonable access. Under Section 1860-D-4(c)(5)(D), a sponsor shall, based on the preferences submitted by the at-risk beneficiary, select prescriber(s) and pharmacy(ies) that ensure "reasonable access". Reasonable access is defined within that same subparagraph as "taking into account geographic location, beneficiary preference, impact on cost-sharing, and reasonable travel time" and shall be ensured "in the case of individuals with multiple residents, in the case of natural disasters and similar situations, and in the case of the provision of emergency services." We are unclear on what role(s) the sponsor, pharmacy, and potential prescribing emergency physician will each have in such emergency services encounters to ensure this access. ACEP fully appreciates the careful balance that can be involved in providing at risk beneficiaries with needed medications while also ensuring the goal of the drug management program to reduce inappropriate access to frequently abused drugs, and seeks clarity on how CMS envisions this process.

Medicare Advantage and Part D Prescription Drug Plan Quality Rating System

CMS is soliciting feedback from stakeholders on how well the existing Star Ratings create meaningful quality improvement incentives and differentiate plans based on quality, and will use that feedback in considering potential changes to the Star Ratings system measures.

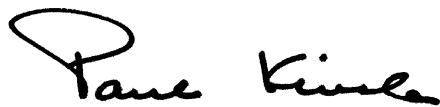
CMS is particularly interested in feedback on several topics, including whether it should consider additional adjustments to the Star Ratings measures or methodology that could further account for "unique geographic and provider market characteristics that affect performance (for example, rural geographies or monopolistic provider geographies)". We disagree that plan performance is being impacted by "monopolistic provider geographies". Rather, plans are increasingly creating narrow networks, which effectively limit the in-network services that an enrollee may need, especially when network adequacy standards are not enforced. A 2015 GAO study even recommended that "The Administrator of CMS should augment oversight of Medicare Advantage Organization (MAO) networks to address provider availability, verify provider information

submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters.”¹ HHS concurred with the recommendations at the time. While we appreciate and are encouraged that the agency has since taken steps over the last year to implement improvements, we must strongly disagree that plans should be provided additional adjustments based on so-called monopolistic provider geographies.

CMS also seeks feedback on whether it should include survey measures of physician experiences in setting Star Ratings, noting that physicians also interact with health and drug plans on a daily basis on behalf of their patients. We strongly applaud CMS’ recognition of the substantial dealings physicians often have with health and drug plans. The quality of these interactions can vary greatly, and frequently add to the already significant administrative burdens physicians face. We would be supportive of CMS developing a survey tool for collecting standardized information on physicians’ experiences with health and drug plans and their services, but would of course urge the agency to ensure the survey remains entirely voluntary and therefore does not in and of itself also become an administrative burden.

We appreciate the opportunity to share our comments and look forward to continuing working with you and your staff. If you have any questions, please contact Laura Wooster, ACEP’s Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,

A handwritten signature in black ink that reads "Paul D. Kivela". The signature is written in a cursive, flowing style.

Paul D. Kivela, MD, MBA, FACEP
ACEP President

¹ Medicare Advantage: Action Needed to Enhance CMS Oversight of Provider Network Adequacy. GAO 15-710. September, 2015