April 3, 2020

Seema Verma
Administrator, Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Attention: CMS-4190-P

Dear Administrator Verma,

On behalf of URAC, I respectfully offer our comments in response to the proposed rule implementing policy and technical changes for Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D) program and Medicaid.

URAC is an independent, nationally recognized accrediting entity with thirty years of experience accrediting managed care and provider organizations. Further highlighting our independence, we do not sell consulting services of any type. URAC Accreditation is recognized by CMS to augment the federal government's oversight of Qualified Health Plans (QHPs), Medicaid managed care organizations (MCOs), Medicare Advantage Organizations, and Medicare Home Infusion Therapy Suppliers. As the leading accreditor of pharmacy quality management, including specialty pharmacies and pharmacy benefit managers (PBMs), URAC has extensive knowledge of network adequacy as it relates to the management of both medical and pharmacy benefits. URAC accreditation applicable to Independent Review Organizations (IROs) that perform external review is also recognized by CMS and insurance regulators as promulgated under the NAIC Uniform Health Carrier External Review Model Act § 12 and as required under the ACA (Public Law 111-148 § 2719).

URAC supports CMS's plans to codify certain provisions from the Comprehensive Addiction and Recovery Act of 2016 (CARA), Bipartisan Budget Act of 2018 (BBA), the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) and the 21st Century Cures Act (Cures Act). In addition, we are encouraged by CMS's continued efforts to streamline regulations and reduce regulatory burden as part of the Patients over Paperwork initiative.

As detailed in our comments included with this letter, URAC strongly supports the implementation of pharmacy performance measure reporting requirements and the automatic escalation to external review under a Medicare Part D Drug Management Program (DMP) for at-risk beneficiaries. We are encouraged by some of the proposed changes to network adequacy under Medicare Advantage, but urge CMS to not limit this evaluation to purely quantitative information.

As CMS continues to work to enhance the Part C and D programs, URAC stands ready to support your efforts wherever possible. Please do not hesitate to call on URAC as a resource at any time. Please contact Aaron Turner-Phifer, Vice President of Government Relations and Policy, if you have any questions or wish to discuss anything in detail at aturner-phifer@urac.org.

Sincerely,

Shawn Griffin, M.D.

Shawn Griffin, M.D.
President and CEO

Establishing Pharmacy Performance Measure Reporting Requirements (§ 423.514)

URAC strongly supports the proposed requirement to have Part D sponsors disclose the pharmacy performance measures they use to evaluate pharmacies in their network. Given our experience as an accreditor of both specialty pharmacies and pharmacy benefit managers (PBMs), URAC has unique insight as it relates to pharmacy quality. We currently accredit over 450 specialty pharmacies that run the gamut of national chain and regional-based pharmacies, small, independent, community pharmacies and hospital/health-system based pharmacies. We also accredit the leading PBMs that service Part D sponsors including OptumRx, CVS Caremark, Express Scripts, and MedImpact.

URAC has required our accredited specialty pharmacies to report on key performance measures since 2016 and started publicly releasing aggregated de-identified measure data in 2017. Our mandatory performance measures reflect critical functional elements of specialty pharmacies such as call center performance, dispensing accuracy, distribution accuracy, and prescription turn-around time. In addition, we also have measurement reporting related to drug-drug interactions and consumer experience that are not required but encouraged to better understand the quality of care and service delivery of our accredited specialty pharmacies.

We believe that CMS's proposal to publish the list of pharmacy performance measures will reiterate the importance of standardization in performance measurement. In turn, this will also better inform consumers about critical metrics that their pharmacies are being held accountable to by their Part D sponsors. Public reporting will underscore the need for consensus within the industry about the critically-few measures needed to really assess a pharmacy's performance which will serve to support the Trump Administration's continued efforts to minimize administrative burden as part of the Patients over Paperwork initiative. By publishing the performance measures they use, Part D sponsors and the industry at large can work together to ensure minimal variability. This will promote alignment across plans and minimize the need for pharmacies to collect potentially duplicative measures and ensure the associated technical specifications for each measure are appropriate.

Furthermore, given the ongoing conversation about drug pricing and related expenditures on high-cost, specialty medications within Part D, it is vital that CMS continue to advance Part D reporting requirements to ensure beneficiaries have access to high quality care. However, this need for information should be balanced against potential reporting burden. In keeping with this, URAC doesn't require performance measure reporting within the first year of an accreditation to allow pharmacies time to familiarize themselves with measure reporting requirements and have the appropriate processes in place to submit meaningful data. We also do not require designated small pharmacies to report measures given their limited resources. To ensure minimal reporting burden, we encourage CMS to work with Part D sponsors on implementing a glide-path for small, independent and/or rural pharmacies to report performance measures. In terms of reporting timelines, URAC has found that collecting measures on an annual basis during a designated reporting period via a secure web-based platform has been well received. Our reporting cycle requires accredited pharmacies to submit measures between July and September every year using data obtained during the previous calendar year (i.e., measures for CY 2018 were reported in July-September of CY 2019).

In addition, CMS should ensure the performance measures that are required to be reported by Part D network pharmacies have been validated by a third-party, independent organization to ensure accuracy. Given the potential penalties that can be imposed on a network pharmacy with poor

results, it is vital that the information being reported accurately reflects the pharmacies' performance and doesn't have the unintended consequence of introducing bias related to technological capabilities or anything else that could unduly skew results. Additionally, data validation will lend credibility to the information being used to determine reimbursement. Lastly, in determining which pharmacy performance measures should be used, URAC believes the following guiding principles should provide a sound framework: use of publicly available, nationally endorsed measures, use of measures that promote efficiency and effectiveness, ensuring manageable administrative burden, and only measuring what matters. Ultimately, all performance measures should promote the triple aim of lower cost, better outcomes and improved experience.

As such, URAC supports CMS's goal of increased public transparency and better communicating the role of pharmacies and pharmacists in the continued move to value-based care through this proposal. We would be happy to lend our expertise in this area and share our knowledge at your convenience given we are the only independent organization with validated pharmacy performance measurement data. Additionally, since we have been collecting measures for nearly five years, we could also provide our insights related to trends that we have seen over time. We encourage CMS to consider leveraging URAC as a pharmacy measure steward given our extensive work in pharmacy quality management and independence.

Automatic Escalation to External Review under a Medicare Part D Drug Management Program (DMP) for At-Risk Beneficiaries (§§ 423.153, 423. 590, and 423.600)

URAC supports the proposal to automatically escalate redeterminations associated with DMP appeals to the Part D independent review entity (IRE). Given our position as the accreditor of independent review organizations (IRO), or IREs that are typically responsible for providing external reviews, we are sensitive to the importance of timeliness for urgent cases. As such, automatically escalating an appeal for an at-risk determination to an IRE without having to wait for the enrollee or prescriber on their behalf to request a review will only serve to reduce the lag time in final determinations being issued and enable patients to access needed care sooner. Accordingly, we support the proposed changes to the required initial and second notice in addition to adjudication timeframes and redetermination responsibilities. While recognizing CMS has required IREs to "solicit the views of the prescribing physician or other prescriber [for] determinations that are auto-forwarded to the IRE", we encourage CMS to reiterate the need for the prescribing physician to provide all requested information associated with the adverse decision to the IRE within a timely manner. Additionally, we urge CMS to consider requiring the IRE to make a good faith effort to obtain relevant information from the prescribing physician in instances in which there is not an automatic escalation as well to ensure consistency in the resolution of all cases involving Part D appeals.

Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

URAC supports CMS's proposal to modify network adequacy requirements to "take into account the impact of telehealth providers" but encourage CMS to reconsider their approach to the blanket use of time and distance standards. While acknowledging CMS's care in defining time and distance standards at the county level, due to the variability that can exist, we urge CMS to reconsider codifying a uniformly applied time and distance standard. We believe that meeting the needs of the community should be prioritized over meeting an arbitrary numeric standard that merely represents a point in time. To ensure that there are no gaps in the assessment of the network adequacy of an MA plan, URAC urges CMS to allow for the use of a combination of qualitative and quantitative standards. While supportive of CMS's inclusion of a combination of quantitative

elements like time and distance standards and minimum number of provider requirements, the information captured in a qualitative assessment is invaluable and particularly useful when trying to gauge patient satisfaction.

Furthermore, while not proposed at this time, URAC would be supportive of CMS allowing telehealth to be included as part of network adequacy calculations for MA plans. If CMS does eventually allow for this, the quality of telehealth services must be closely monitored by the plans and CMS. While studies have shown that some telehealth services can be provided as a substitute for in-person care with no difference in quality for the patient, this is not true of every service. The increased use of telehealth is relatively new compared to the decades of experience regulators have related to the construct of networks solely comprised of in-office physicians. CMS and MA plans have a responsibility to Medicare beneficiaries to ensure that incentivizing the use of telehealth and the accompanying increase in telehealth providers does not weaken the quality of care that patients receive.

Given our position as a managed care accreditor, URAC has seen several different approaches to network adequacy. Health plans that develop a system to routinely monitor their provider network against the clinical needs of their enrolled population have proven to be the most effective. While most health plans do employ a variety of quantitative standards, those that have a continuous process for monitoring access are more effective at identifying and alleviating access issues. Our experience has taught us that having the means to build, manage and evaluate one's provider network against the needs of the population is the best way to ensure network adequacy and protect consumers.

Additionally, URAC supports CMS's proposal to give MA plans a 10-percentage point credit for contracting with telehealth providers in the defined specialty types of dermatology, psychiatry, neurology, otolaryngology and cardiology. We think this credit is an appropriate amount due to the importance of telehealth in addressing narrow provider networks. Telehealth has been proven to be a useful tool for consumers because of its convenience, accessibility and ability to enhance patient engagement – all of which improve patient outcomes. And, while acknowledging the ability of telehealth to give beneficiaries more choice, we echo previous comments that beneficiaries should still have access to in-person visits. Moreover, if CMS adopts the proposal to give MA plans a 10-percentage point credit for contracting with telehealth providers for certain specialties, the quality of services rendered should be continuously monitored to ensure beneficiaries have access to high-quality care. While not yet part of an MA plans' network adequacy evaluations, we applaud CMS for taking this step to acknowledge the role of telehealth.