AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 5, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

RE: CMS–9895–P; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters (NBPP) for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing 129,600 family physicians and medical students across the country, I write in response to the proposed rule for the 2025 Notice of Benefit and Payment Parameters, as published on November 24, 2023, in the Federal Register.

The AAFP has long supported affordable, comprehensive coverage. Family physicians see firsthand how lack of comprehensive coverage and high out-of-pocket costs adversely impact patients and can cause patients to delay necessary care out of fear of being unable to afford it. **To further bolster coverage, the AAFP recommends CMS:**

- **Finalize a federal floor for time and distance network adequacy standards to be applied across exchange types,**
- **Separate mental health and substance use treatment standards,**
- **Finalize the proposed Medicaid disregard flexibilities, and**
- **Consider guardrails for individuals being automatically enrolled in a new plan to ensure the new plan is affordable and meets the needs of the individual or their family.**

Establishment of Exchange Network Adequacy Standards (§ 155.1050)

CMS proposes to require that State Exchanges and State-based marketplaces that use the federal enrollment platform (SBE–FPs) establish and impose quantitative time and distance network adequacy standards for qualified health plans (QHPs) that are at least as stringent as the federally-facilitated exchanges' (FFEs') network adequacy standards established for QHPs.

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The AAFP supports this proposal to establish and align time and distance standards for State Exchanges and SBE-FPs. The AAFP has long supported minimum federal network adequacy standards in order to facilitate timely, equitable access to comprehensive primary care and other services, and we applauded HHS for reinstating these for QHPs in the 2023 NBPP proposed rule. Likewise, we applaud HHS and CMS for extending these network adequacy requirements to State Exchanges and SBE-FPs and aligning the standards. The AAFP regularly advocates for administrative simplification to ensure patients, physicians, and payors can better understand their rights and requirements under regulations, including network adequacy regulations.

The AAFP notes that the current network adequacy standards for QHPs and proposed standards for State Exchanges and SBE-FPs do not separate out mental health and substance use disorder (SUD) treatment options. By lumping SUD treatment in with other mental health services their availability may be overestimated in QHP networks. The AAFP is concerned that, without further specification, enrollees may experience challenges accessing in-network SUD treatment services. We note that many family physicians provide buprenorphine treatment in their practices, often serving as the only source of outpatient SUD treatment in their communities. Time and distance standards should recognize the availability of SUD treatment in primary care clinics and also acknowledge the limited capacity these practices have to take on new patients due to regulatory and other requirements. The AAFP recommends HHS separately monitor time and distance to both inpatient and outpatient SUD treatment services and consider implementing separate standards for SUD treatment in future rulemaking.

Further, the AAFP strongly urges CMS to consider robust wait time standards for State Exchanges and SBEs. Maintaining a robust network of primary care physicians and ensuring timely access to routine primary care are foundational components of comprehensive health coverage. Patients often first seek care for an acute or chronic issue with their primary care physician and most rely on them completely for recommended preventive services. Existing appointment wait time standards for routine primary care vary across plans and coverage types. We've found that a 10-day maximum standard wait time is relatively common and appropriate in many areas. Additionally, the AAFP was strongly supportive of the proposed wait time standards for QHPs in 2023, though they were later delayed until 2025. **The AAFP strongly recommends implementing the wait time standards for QHPs in 2025 as previously finalized and requiring State exchanges and SBEs to impose comparable standards in a future rule.**

As mentioned above, distinct standards for SUD treatment may be appropriate. Given the well documented lack of SUD treatment providers, the importance of care continuity throughout SUD treatment, and the potential harm that could be caused by long appointment wait times, we believe different standards may be needed to ensure equitable access to SUD care for State Exchange and SBE-FP enrollees.

CMS also proposes that State Exchanges and SBE–FPs be required to conduct quantitative network adequacy reviews prior to certifying any plan as a QHP, consistent with the reviews conducted by the FFEs. CMS includes a justification process for plans that do not initially pass the review to account for variances and potentially earn QHP certification.

The AAFP strongly supports this provision and agrees that plans should be compliant with network adequacy requirements before being certified as a QHP. As noted in the proposed rule, quantitative network adequacy reviews are relatively simple to complete, and some states have already taken steps to complete this review prior to certification. Plans that offer a narrow selection of in-network clinicians, many of whom may not be accepting new patients, significantly reduce patient

access to care and can result in care delays or higher out-of-pocket costs if a patient must see an out-of-network clinician.

Finally, CMS proposes to mandate that State Exchanges and SBE–FPs require all issuers seeking QHP certification to submit information to the State Exchange or SBE–FP about whether network providers offer telehealth services. The purpose of this provision is to collect data and monitor availability of telehealth services to inform the future development of telehealth standards and would not be displayed to consumers. CMS specifically notes that this provision is not intended "to suggest that telehealth services would be counted in place of in-person service access for the purpose of meeting network adequacy standards for PY 2025."

The AAFP appreciates CMS' clear language that this provision is not intended to count telehealth in place of in-person services, and the AAFP supports data collection of telehealth services. The AAFP strongly recommends that any studies of telehealth utilization analyze volume, patterns, and patient outcomes for visits provided by a patient's usual source of care versus one-off visits provided by a clinician with whom the patient has no relationship.

With regard to potential future telehealth standards, the AAFP supports the existing requirement for providers to offer in-person services in addition to telehealth services for telehealth services to be counted towards meeting appointment wait time standards. The AAFP agrees that telehealth services do not replace the availability of in-person care in a robust network. We've previously noted concerns with the proliferation of direct-to-consumer (DTC) telehealth vendors and the resulting care fragmentation. Recent reports regarding the provision of virtual-only care also raise concerns about negative impacts on patient safety and wellbeing, in addition to a lack of oversight. Thus, we believe the existing requirement strikes the appropriate balance of promoting access to care while protecting enrollees.

Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR 435.601)

HHS proposes to allow state Medicaid programs to tailor their use of income and resource disregards to ease eligibility rules for specific populations. Generally, Medicaid populations are evaluated on income eligibility based on a modified adjusted gross income (MAGI). The ACA effectively removed resource tests that look at an individual's financial assets and replaced it with the MAGI analysis, except for populations who are aged 65 years or older, are blind or disabled, or are being evaluated for coverage as medically needy. For these populations under non-MAGI rules, states can disregard portions of income or assets that otherwise would make individuals ineligible for Medicaid coverage. This effectively expands access to Medicaid coverage for individuals who would benefit from Medicaid and face challenges obtaining affordable, comprehensive coverage elsewhere. Current regulations require that states apply the disregard to all individuals in the eligibility group, which has significantly impaired state's ability to implement more specific disregards for specific non-MAGI eligible populations. Because of the current all-or-nothing approach, many populations, most significantly individuals with disabilities, cannot receive targeted disregards because applying it to the entire population would not be financially or otherwise feasible.

The AAFP supports this proposal to further expand access to Medicaid, and we urge HHS to closely monitor how states implement the new disregard flexibility. State implementation of this disregard flexibility could provide important information about current eligibility barriers for certain populations and point to broader reforms for federal policymakers to consider. As such, the AAFP supports HHS monitoring state implementation of this new flexibility and strongly urges CMS to finalize this as proposed.

Provision of Essential Health Benefit (EHB) (§ 156.115)

CMS proposes to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB.

The AAFP supports this proposal and actively encourages collaboration between family physicians and dental health practitioners to provide comprehensive oral health care at all stages of life. Compromised oral health is associated with cardiovascular disease, endocarditis, diabetes, premature birth, low-birth weight, pneumonia, and malnutrition. Patients' concerns over oral health and frustration over lack of coverage are brought up in visits with primary care physicians, thus the AAFP is acutely aware of the impact lack of coverage for dental services has on patients. As noted in the proposal, "it is up to each State to consider the potential costs and network burden and determine whether to add routine non-pediatric dental services as an EHB."

Non-Standardized Plan Option Limits (§ 156.202)

CMS proposes an exceptions process that would allow issuers to offer more than two non-standardized plan options per product network type, metal level, inclusion of dental and vision benefit coverage, and service area if the issuer can demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions. These plans should "have reduced cost sharing of 25 percent or more for benefits pertaining to the treatment of chronic and high-cost conditions, relative to an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area."

The AAFP agrees with increasing accessibility to chronic care by reducing out-of-pocket costs for chronic or high-cost care. However, as these plans are implemented, CMS should consider whether it would be beneficial to compare non-standard plans to standard plans. Allowing plans to compare non-standard plans against other non-standard plans could diminish the effect of reducing health care costs if the non-standard plan comparison includes a higher out of pocket level than the standard plan. Further, any reduction in out-of-pocket costs to patients should be reflected as increases in plan payments made to the practice to adequately reflect the full value of the services provided.

Verification Process Related to Eligibility for Enrollment in a QHP Through the Exchange (§ 155.315(e))

CMS proposes to permit all Exchanges to accept consumer attestation of incarceration status without further electronic verification and to permit Exchanges to verify consumer incarceration status using an HHS-approved verification data source that is current, accurate, and minimizes administrative costs and burdens.

The AAFP strongly supports this proposal. As stated in the proposed rule, incarcerated individuals apply for QHP coverage at very low rates and their applications are considered to be a very low program integrity risk for Exchanges. Moreover, data shows Black adults are imprisoned at five times the rate for White adults and are more likely to face systemic obstacles hindering their ability to secure employment (and therefore employer-based coverage) post incarceration.[i, ii, iii] Thus, previous guidance to conduct incarceration status verification adversely and inequitably impacts timely and appropriate enrollment, particularly for Black adults. This proposed change will allow for more equitable enrollment in QHPs, and the AAFP applauds CMS for taking such action. We strongly urge CMS to finalize this provision as proposed.

Incorporation of Catastrophic Coverage Into the Auto Re-Enrollment Hierarchy (§ 155.335(j))

CMS proposes to require Exchanges to re-enroll individuals who are enrolled in catastrophic coverage, as defined in section 1302(e) of the ACA, into a new QHP for the coming plan year; ensure continuity of coverage in cases where the issuer does not continue to offer a catastrophic plan for the new plan year, or these individuals are no longer eligible for enrollment in a catastrophic plan for the new year, and these individuals do not actively select a different QHP.

The AAFP appreciates CMS' focus on ensuring continuity of coverage, but we encourage CMS to implement guardrails to ensure individuals are not automatically enrolled in a plan they cannot afford or that no longer suits their needs. While the proposed provision requires that beneficiaries are enrolled in a bronze metal level QHP in the same product as the enrollee's current QHP, a plan that has the most similar network compared to the enrollee's current QHP, or the otherwise lowest coverage level offered under the product in which the enrollee's current QHP is offered, the AAFP is concerned that beneficiaries may be enrolled in plans that are unaffordable or do not meet their needs. CMS could consider a limit on the increase in premium or out-of-pocket cost for automatic enrollment or require plans to complete appropriate notification processes before proceeding with automatic re-enrollment.

Thank you for the opportunity to provide this feedback. The AAFP looks forward to working with your agency to further patient access to affordable and comprehensive health care coverage. For additional questions, please contact Morgan Bailie, Senior Regulatory Specialist, at mbailie@aafp.org.

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Nellis, A. (2021). *The Color of Justice: Racial and Ethnic Disparity in State Prisons.* The Sentencing Project. https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf

[ii] Sabol, W.J., and Johnson, T.L. (2022). *Justice System Disparities: Black-White National Imprisonment Trends, 2000 to 2020.* Council on Criminal Justice. https://secure.counciloncj.org/np/viewDocument

[iii] Sirios, C., and Western, B. (2017, Feb.). *Racial Inequality in Employment and Earnings after Incarceration.* Harvard University. https://scholar.harvard.edu/files/brucewestern/files/racial_inequality_in_employment_and_earnings_after_incarceration.pdf