



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 18, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled, "HHS Notice of Benefit and Payment Parameters for 2016" published by Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* on November 26, 2014. This proposed rule makes several policy adjustments to federally facilitated exchanges. The AAFP continues to support efforts to improve patient access to affordable health insurance coverage.

Coverage of Primary Care

Before we react to sections of this proposed rule that impact primary care physicians, the AAFP respectfully requests that CMS include in the final rule a detailed discussion of coverage of primary care within federally facilitated exchanges. In the CMS draft 2015 letter to issuers in the federally facilitated marketplaces posted on February 4, 2014, the AAFP was pleased to see Section 7 titled, "Coverage of Primary Care: 2015 Approach". This section discussed how CMS is:

...considering whether to require through rulemaking that all plans, or at least one plan at each metal level per issuer, cover three primary care office visits prior to meeting any deductible. We encourage QHP issuers in the FFMs to cover three primary care office visits prior to meeting any deductible.

As articulated in the AAFP's February 24 comment [letter](#), the AAFP appreciated that CMS recognized and encouraged the value of primary care services for patients. However, rather than only [encourage](#) QHP issuers to cover three primary care office visits prior to applying any annual patient deductible or coinsurance/co-payment, the AAFP instead urges CMS to [require](#) that issuers not apply any deductible or coinsurance/co-payment to the first three primary care visits so that patients would enjoy "first dollar coverage" for those visits. The final 2015 letter to issuers did not discuss this section and the AAFP strongly encourages CMS to fully address this policy within future rulemaking. We especially believe this to be important since many patients, especially those gaining health insurance for the first time, will have long-neglected ailments. The three-visit requirement would provide an appropriate incentive to beneficiaries to see their primary care physician in a patient-centered medical home to address those ailments and thus prevent costlier care down the road. In essence, the three-visit requirement promotes preventive, rather than reactive, medicine, which the AAFP considers to be in the best of interest of patients. Furthermore, it is consistent with the AAFP's [policy](#) on "Health Care for All," which advocates that

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primary care provided by or through the medical home should have no financial barriers such as co-payments.

Pharmacy & Therapeutics Committee

Within this proposed rule and in terms of the requirements of the prescription drug benefit within the essential health benefits, CMS suggests replacing the current drug count standard with a pharmacy and therapeutics (P&T) committee. Plans would use that committee to ensure the plan's formulary drug list covers a sufficient number and type of prescription drugs. CMS believes that the use of a P&T committee in conjunction with the other standards will help ensure that an issuer's formulary drug list covers a broad array of prescription drugs and provide enrollees with a more robust formulary drug list. Overall, the AAFP supports this approach.

Regarding P&T committee membership, CMS proposes members from a sufficient number of clinical specialties to adequately represent the needs of enrollees. Since family physicians treat patients with a variety of ages, diseases, and conditions, family physicians prescribe a wide range of medications. The AAFP therefore strongly encourages CMS to require P&T committees to have dedicated seats for practicing family physicians. Furthermore, since the P&T committees are intended to create medication formulary lists, the AAFP encourages CMS to specify that only practicing health care professionals who can prescribe drugs be eligible to serve on a P&T committee. It is AAFP [policy](#) on "Patient-Centered Formularies" regarding P&T committees that:

- Health plans should constitute P&T committees with plan payers, members and local practitioners who are credible and respected to review, revise as appropriate and approve formularies, including those provided to the health plan by contracted pharmacy benefit managers.
- All P&T committee members should be required to disclose significant pharmaceutical company-related stock holdings.

We urge CMS to accept these recommendations to ensure that the P&T committees remain focused on primary care.

Exceptions Process

This proposed rule also discusses how issuers of essential health benefit plans must have procedures in place to allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician to request access to clinically appropriate drugs not covered by the plan. Commonly referred to as the "exceptions process," plans must respond within 72 hours for standard reviews or within 24 hours for expedited reviews based on serious health conditions. The AAFP reviewed these timeframes and generally find them to be reasonable. However, the AAFP believes physicians and their patients deserve an exceptions process that helps determine appropriate care based on the patient's condition and established coverage rather than one that simply serves as a cost-containment mechanism. To the greatest extent possible, the AAFP urges CMS and health plans to decrease administrative burdens involved with prescribing medications and avoid needless delays that can usurp appropriate medical care for patients. It is AAFP [policy](#) that physicians have the right under their medical license to diagnose, prescribe for, and dispense pharmacologic agents or other therapeutic products whenever and wherever it is appropriate.

Network Adequacy Standards

CMS established minimum network adequacy criteria that health plans must meet to be certified as qualified health plans. CMS proposes to modify these requirements and specify that qualified health plans must use a provider network and that a provider network includes only providers that are contracted as in-network. This would mean that the general availability of out-of-network providers will not be counted for purposes of meeting network adequacy requirements.

The AAFP outlined our concerns with ensuring networks have robust access to primary care physicians in [letters](#) sent to CMS and other insurance providers on July 24, 2014. The AAFP continues to believe that primary care is the most cost-effective access point for care and that reducing access at this entry point is shortsighted. We also believe that properly constructed narrow/high-value networks can save money for patients when family physicians have wider leeway to coordinate a patient's care with specialists, other providers, and hospitals. The AAFP is growing increasingly concerned with tactics deployed by health insurance companies whereby they arbitrarily eliminate physicians from their network forcing patients to identify and secure the services of a new physician. This so-called "network optimization" is disruptive to patients and their physicians, and the AAFP urges CMS and plans to minimize such actions.

Overall, the AAFP supports the proposal for plans to update their provider directory information at least once a month and for the plans to make this easily accessible to general public in a manner that easily discerns which providers participate in which plan(s) and provider network(s) if the health plan issuer maintains multiple provider networks.

Re-enrollment

Current CMS re-enrollment policy prioritizes re-enrollment with the same issuer in the same or a similar plan with the goal of maximizing continuity of coverage and care. However, because premiums may change significantly from one year to the next, the plans that are most competitively priced in one year may not continue to be the most competitively priced in subsequent years. For this reason, default enrollment in the same or similar plan could result in consumers remaining in plans that are significantly more expensive than the patient would pay for similar coverage by other plans. CMS believes that consumers place a high value on low premiums when selecting a plan. Thus, CMS is exploring an approach under which an enrollee, at the time of initial enrollment, would choose among re-enrollment hierarchies. Under this approach, the enrollee could opt into being re-enrolled by default for the subsequent year into a low-cost plan (such as the QHP of the same metal level with the lowest premium in the enrollee's service area, or one of the three such QHPs with the lowest premiums by random allocation), rather than his or her current plan or the plan specified in the current reenrollment hierarchy.

Overall, the AAFP supports efforts that maximize continuity of coverage and care, although we also recognize the high value consumers place on low premiums. The AAFP supports giving impacted consumers the option to opt in to the alternative hierarchy of their choice during open enrollment in 2015 (or during special enrollment periods occurring during 2016). The AAFP urges CMS to help educate consumers about the risks of being default re-enrolled in a plan with a significantly different provider network, benefits, cost-sharing structure, or service area. The AAFP encourages HHS to simplify patients' transitions between plans through policies that reduce administrative burdens, such as portability of prescriptions and prior authorizations.

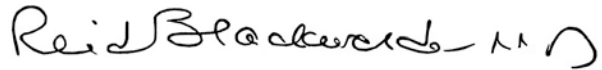
Administrator Tavenner

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We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Reid B. Blackwelder MD". The signature is written in a cursive style with a large, stylized initial "R" and a distinct "D" at the end.

Reid B. Blackwelder, MD, FAAFP
Board Chair