December 16, 2015

Sylvia M. Burwell, Secretary
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: HHS Notice of Benefit and Payment Parameters for 2017 (CMS–9937–P)

Dear Secretary Burwell and Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the proposed rule titled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017" as published in the December 2, 2015 *Federal Register*. Among several other provisions, this proposed rule establishes payment policies for the federally facilitated Marketplaces operating in 2017. The AAFP continues to support efforts to improve patient access to affordable health insurance coverage and we offer the following comments to sections of this proposed rule that impact primary care physicians.

Standardizing Plans Offered in the Exchanges

The AAFP supports standardizing plans offered in the federally facilitated Marketplaces as a means to reduce consumers' confusion when they are selecting health insurance. Various states have taken this approach, most notably California with the Covered California initiative. Displaying standardized plans would enable consumers to compare costs and benefits of qualified health plans (QHPs) and easily identify which one works best for them or their family. In addition, the AAFP applauds the Centers for Medicare & Medicaid Services (CMS) for including primary care visits, generic drugs, and other services as a covered benefit before the deductible is applied in standardized plans. The AAFP appreciates CMS recognizing and encouraging the value of primary care for patients who would enjoy "first dollar coverage" for that care. We believe this insurance design feature to be extremely important for patients with long-neglected ailments, who are gaining health insurance for the first time. Covering primary care visits, generic drugs, and other services as a covered benefit before the deductible is applied would provide an appropriate incentive to enrollees to use the preventive care and chronic disease management, as well as early diagnosis and treatment of acute conditions offered by family physicians and other primary care providers. Furthermore, this essential health

benefit is consistent with the AAFP's policy on "Health Care for All," which advocates that primary care is provided through the patient-centered medical home and that patients should have no financial barriers, such as co-payments, that might impede access to their family physician. For this reason, primary care should be covered without a deductible at all three levels of health plans. With the shift to value-based care and payment, CMS acknowledges the importance of primary care in achieving improved health, better health care, and lower cost. Additionally, exempting primary care services from the deductible would encourage consumers to visit their primary care physician for conditions they might feel they could ignore. When Navigators, which are entities that help consumers apply for and enroll in Marketplace health plans, emphasize this benefit, then access to care for routine, chronic, and neglected conditions would increase, overall medical spending would be restrained (by reductions in hospitalization, emergency visits, etc.) and enrollees would realize some clear value for their premium dollars.

While QHPs are not required to offer these standardized plans yet, the AAFP encourages CMS to seriously consider making these standardized plans mandatory with additional input from providers, payers, patients, and purchasers. Furthermore, payers and providers are boldly developing and deploying novel and innovative health care delivery models under programs of value-based care and payment. Therefore, the AAFP respectfully asks CMS to remain open and receive feedback from all stakeholders on alternative benefit designs that improve the experience of care, improve the health of populations, reduce per-capita costs of health care all while increasing consumer choice, understanding, and access.

CMS requests comments on how cost sharing in standardized plans would work, considering varying state limits on cost sharing for certain services. In the agency's analysis of cost sharing, the AAFP strongly urges CMS to take into account quality, outcomes and patient satisfaction and to utilize the principles of a unique concept called value-based insurance design (VBID). The AAFP offers its policy on VBID and calls attention to the work of the University of Michigan's Center for VBID. In addition, the AAFP is aware of the Center for Medicare & Medicaid Innovation's (CMMI) Medicare Advantage VBID Model and applauds this initiative. In the CMS analysis of cost sharing and CMMI's experiment in VBID, the AAFP hopes both entities actively involve practicing physicians to ensure patients have access to the care they need and deserve.

Navigators

Overall, the AAFP appreciates that CMS established a range of programs, like the Navigator program, to help consumers apply for and enroll in Marketplace health plans. Among other important duties, the Navigators help consumers understand the differences in cost and coverage between a visit to the emergency department and a visit to a primary care provider. The AAFP encourages CMS and health plans to take further steps and provide consumers with information regarding the cost and coverage differences between primary care providers and sub-specialty providers and between office-based settings and facility-based settings. This additional information would improve consumers' ability to make informed decisions about plan enrollment, clinical care, and costs. During this third enrollment period, a large number of people enrolling will have never had health insurance and will need substantial education on how to use their insurance.

Network Adequacy

The AAFP appreciates the December 3 letter that CMS provided in response to several AAFP letters regarding the frequency of updates to directories of providers that health plan issuers offered to Marketplace and Medicare Advantage enrollees. We fully agree that protecting consumer access to health care providers is important since accurate and current provider directories are essential for accessibility. Without these directories, beneficiaries face unfair, costly, and protracted obstacles to the care, treatment, and management they need. In the case of family medicine, accurate and up-to-date physician directories ensure that this entry point for health care coverage stays open and accessible for patients. Furthermore, accurate and up-to-date

directories will not only benefit patients in finding the care they need but also help providers make appropriate referrals when further, specialized treatment is warranted.

The AAFP supports the CMS proposal to require Marketplaces to notify enrollees about a discontinuation in network coverage of a contracted provider. We also agree with CMS that notifying enrollees of changes to the network on a timely basis is important since they cannot make choices about coverage and cost without accurate information about which providers are in-network. While the proposed 30-day notification timeframe is appropriate, the AAFP encourages CMS and issuers to explore methods to notify enrollees about provider network changes even more promptly.

In addition, the AAFP acknowledges that physicians have a role in contributing to the accuracy of provider directories. However, the AAFP is concerned that this responsibility could create further administrative hassles for physicians and could affect the number of physicians who choose to treat Medicare patients. The method for providers to update and for CMS and private payers to maintain up-to-date provider directories should be automated. Entering provider information should be web-based, allowing the provider to log into a secure website to make changes to:

- Practice name, street address, city, state, zip code, phone number, website, etc.;
- Practice office hours and other information that could affect availability;
- The availability of the provider for new patients; and
- The anticipated time period for accepting or not accepting new Medicaid patients.

We also are encouraged that CMS asked states to establish a provider network adequacy standard for health plans. However, both the proposed rule and the CMS response to the AAFP note that this proposal will be subject to minimum criteria that will be established later. Given the importance of accurate and up-to-date provider directories, the AAFP recommends that CMS not delay and immediately establish and enforce a provider network adequacy standard. In assessing network adequacy, CMS and states must account for a number of factors. The AAFP is pleased with the time and distance network adequacy requirements, at the county level, that CMS proposed and would ask that standards be set for appointment wait times as well. A study last year by HHS' Inspector General found only half the doctors listed in official plan directories were taking new Medicaid managed care patients. Among those doctors who were, one-fourth could not see patients for a month. Standards on appointment wait times would add an additional beneficiary protection.

Provider Termination from Networks

The issue of network adequacy stems, at least in part, from a problem regarding unfair provider termination from networks, without cause. As long ago as July 2014, the AAFP noted in a letter to CMS our concerns with UnitedHealthcare arbitrarily dropping physicians from networks. The AAFP would urge CMS and private payers to make public the performance measures, in addition to patient feedback, used in determining which providers are included in which network. Providers and consumers should have information on the performance measures that the plan used and, if the plan did not use performance measures, the plan should make public which methods and metrics were used to create the network.

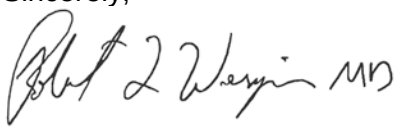
While the proposed rule provides various consumer assistance programs and protections, there is no mention of protections for providers if they are unfairly terminated from networks. Physicians should have an appeals process in place to ensure impartial network determinations. The appeals process for providers should mirror the process for consumers in that it should be fair, timely, transparent and rarely needed.

The AAFP continues to believe that primary care is the most cost-effective access point for care and that reducing access to primary care 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. In addition, the use of tiered provider networks and formularies must be regulated to ensure that consumers of all ages have access to all covered services, including specialty services, without additional and unreasonable cost sharing. The AAFP remains concerned with tactics deployed by health insurance companies that arbitrarily eliminate physicians from networks with little notice and no appeal. This so-called "network optimization" is disruptive to patients and their physicians, and the AAFP urges CMS and plans to minimize such actions.

For any questions you might have, please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair