AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

January 11, 2016

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

Dear 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 write in response to the proposed guidance titled "Draft 2017 Letter to Issuers in the Federally facilitated Marketplaces" as released by the agency on December 23, 2015.

This letter provides issuers seeking to offer qualified health plans, including stand-alone dental plans, in the federally facilitated marketplaces or the federally facilitated small business health options programs with operational and technical guidance to help them successfully participate in the marketplaces in 2017. As CMS considers such guidance to insurance issuers, the AAFP requests that CMS closely consult the AAFP's December 16, 2015 comment letter sent in response the proposed rule titled, "HHS Notice of Benefit and Payment Parameters for 2017" since many of our recommendations for that proposed rule align with our reaction to this draft letter. The AAFP offers the following comments to sections of this proposed rule that impact primary care physicians.

Chapter 2: Qualified Health Plan, Section 3. Network Adequacy

i. Network Adequacy Standard
Since the AAFP continues to support efforts to improve patient access to affordable health insurance coverage, we likewise support the requirement that qualified health plans using a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." Given our longstanding and continued concerns that insurance issuers are dropping physicians arbitrarily from networks, we are cautiously encouraged that CMS proposes to assess provider networks using a "reasonable access" standard in order to identify networks that fail to provide access without unreasonable delay and we are hopeful that these new policies will provide needed transparency and details for issuers on how to fulfill the requirement to provide reasonable access.

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ii. State Review of Quantitative Network Adequacy Standard
While we recognize that some states are adequately reviewing qualified health plans by using specific quantitative network adequacy standards, the AAFP remains concerned that some states are not properly reviewing and enforcing network adequacy. In this letter, CMS discusses two acceptable and quantifiable network adequacy metrics commonly used in the health insurance industry and recommends that states could adopt one as an acceptable metric. The two metrics are:

- The state prospectively enforces time-and-distance standards at least as stringent as the federally facilitated marketplace standard.
- The state prospectively verifies a minimum ratio of provider to covered person for the specialties with the highest utilization rate for its state.

Though the AAFP understands the benefits and shortcomings of each metric, to the greatest extent possible the AAFP encourages CMS to establish nationally network adequacy standards for plans offered in the federally facilitated Marketplaces as a means to reduce consumers' confusion.

iii. Federal Default Standard - Time and Distance
In this section, CMS outlines the default time-and-distance standard that would apply in states that do not elect to review for network adequacy under a separate quantifiable metric. This approach would evaluate an issuer's network based on the numbers, types, and geographic location of providers in its network and if finalized, these standards would be similar to the time-and-distance standards currently applied to Medicare Advantage plans. CMS proposes the maximum time-and-distance standards as:

Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	CEAC
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	30/15	45/30	80/60	90/75	125/110
Endocrinology	30/15	60/40	100/75	110/90	145/130
Gynecology (OB/GYN)	30/15	45/30	80/60	90/75	125/110
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	30/15	60/40	100/75	110/90	145/130
Mental Health	20/10	45/30	60/45	75/60	110/100
Pediatrics	30/15	45/30	80/60	90/75	125/110
Cardiology	20/10	30/20	50/35	75/60	95/85
Rheumatology	30/15	60/40	100/75	110/90	145/130
Hospitals	20/10	45/30	80/60	75/60	110/100
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110
Inpatient Psychiatric Facility Services	30/15	70/45	100/75	90/75	155/140

In general, the AAFP is pleased with the time-and-distance network adequacy requirements for primary care. We believe these standards should encourage issuers to contract with an increased number of primary care physicians. One additional area of consideration, in the future, would be to calculate time standards based on the availability of public transportation. While public transportation is easily accessible in some metro areas, other areas lack this feature. For example, in the metro area in which the AAFP is headquartered, Kansas City, public transportation is still inadequate. Reaching a primary care clinic 10 miles away would take considerably longer than 15 minutes, with no personal car or public transportation. Those who seek care, with no transportation available, are the most vulnerable and most likely to forgo care simply because they cannot see their physician. Finally, we ask that standards be set for appointment wait times as well. We encourage CMS to monitor adherence to these time, distance, and wait time standards and assess whether further improvements can be made to encourage better access to primary care physicians.

iv. Provider Transitions

In the 2017 payment notice proposed rule, CMS proposed two new requirements for issuers regarding cases when a provider is leaving the network:

- To require issuers to notify enrollees about their network coverage when discontinued by a contracted provider. Specifically, CMS proposed that a plan be required to make a good faith effort to provide written notice of termination of a discontinued provider, 30 days prior to the effective date of the change or otherwise as soon as practicable, to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider whose contract is being discontinued. To satisfy this standard, CMS expects the issuer to work with the provider to obtain the list of affected patients or to use their claims data system to identify enrollees who see the affected providers.
- In cases in which a provider is terminated without cause, CMS proposed to ensure continuity of care for enrollees. Specifically, CMS proposed to require the issuer to allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

Regarding the first proposed requirement, the AAFP agrees with the policy that plans should notify enrollees of changes to the network on a timely basis. This requirement is important since enrollees 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.

Regarding the second proposed requirement, from the patient's perspective the AAFP supports the requirement that issuers allow an enrollee receiving active treatment to continue treatment at in-network cost-sharing rates. However, we have grave concerns that, through this requirement, CMS is acknowledging if not actually promoting the practice of issuers terminating providers without cause. Unfair provider termination from networks without cause continues to undermine the success of federally facilitated marketplaces. The AAFP urges CMS and private payers to make public the performance measures, in addition to patient feedback, used in determining which providers are in the 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. The AAFP remains concerned that there is no mention of protections for providers if they are unfairly terminated from networks. CMS should establish an appeals process for physicians 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.

Since the AAFP is convinced that primary care is the most cost-effective access point for care, we believe plans that reduce access to primary care are shortsighted. The AAFP remains concerned with tactics that health insurance companies deploy 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.

v. Network Transparency
This section discusses how CMS intends to label each qualified health plan network's breadth as compared to other plan networks on HealthCare.gov. The AAFP applauds CMS for focusing on hospitals, adult primary care, and pediatric primary care that reflects the overall network breadth for all three of the indicated specialties. Easy-to-understand labeling of networks for enrollees will provide transparency about the type of coverage they are selecting. When enrollees select plans without sufficient knowledge of the provider network and cost-sharing, they could assume their coverage is still insufficient or too expensive to use and so forgo seeking care and treatment. Network labeling, combined with accurate and up-to-date provider directories and provider lookup tools will empower enrollees to choose the care they need and deserve.

vi. Qualified Health Plan Issuer Data Collection and Reporting Requirements
This section describes how CMS will review qualified health plan issuer compliance with the quality reporting standards related to the Quality Rating System (QRS) and the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) for purposes of plan certification and recertification. While this requirement falls squarely on qualified health plans, the AAFP cautions the agency that this may add to administrative burdens for physicians if the data, measures, and methodology are not harmonized among all plans.

The AAFP strongly urges the agency to streamline, harmonize, and reduce the complexity of quality reporting in the QRS and QHP Enrollee Survey programs. All measures used must be clinically relevant, harmonized among plans, and minimally burdensome to report. To accomplish this, the AAFP recommends the agency use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types.

Chapter 3: Decision Support Tools, Section 1. Provider Directory Links and Provider Lookup Tool

This section of the letter discusses the provider directory links and the provider lookup tool for qualified health plans and how they must publish an up-to-date, accurate, and complete provider directory. In a manner that is easily accessible to plan enrollees and prospective enrollees, this directory includes information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations. CMS considers a provider directory to be up-to-date if the issuer updates it at least monthly. CMS considers a provider directory to be easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer's public website through a clearly identifiable link or tab without having to create or access an account or

enter a policy number. In addition, these directories should be available electronically and easy to read across the array of consumer platforms (mobile phones, tablets, laptops, desktops, etc.).

The AAFP completely agrees that accurate and current provider directories are essential for accessibility. Without them, beneficiaries face unfair, costly, and daunting obstacles to the care, treatment, and management they need. 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.

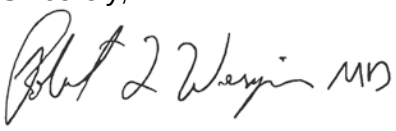
In addition, the AAFP acknowledges that physicians have a role in contributing to the accuracy of provider directories. However, the AAFP is concerned that this responsibility could create further administrative hassles for physicians. Updating provider directories should be automated as much as possible. If the provider must add information, the process should be web-based, allowing the provider to log in to 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 are encouraged that CMS recognizes the need for plans to publish an up-to-date, accurate, and complete provider directory.

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

Sincerely,



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