

January 14, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Acting Administrator Slavitt:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces. The majority of our comments focus on new network adequacy requirements for Qualified Health Plans (QHPs) under Chapter 2, Section 3 of the letter. The AMA is extremely supportive of CMS' proposals to require quantitative standards to evaluate network adequacy and offers suggestions below to help strengthen these proposals for patients. We also make some additional suggestions and express strong support for provisions on prescription drugs.

Network Adequacy (Chapter 2, Section 3)

ii. State Review of Quantitative Standards

As stated in our comments on the 2017 Notice of Benefit and Payment Parameters Proposed Rule, the AMA is very pleased that CMS is proposing a shift toward requiring that quantitative standards be used to measure network adequacy. However, the AMA encourages CMS to require states to use a "set" of standards (e.g., more than two standards) to measure network adequacy, rather than a single measurement. While a time and distance standard or a provider ratio standard alone can help provide a picture of the network, additional standards, such as those that address provider availability and capacity, as well as availability of participating physicians at participating hospitals, create a more comprehensive assessment of the ability of the network plan to meet the needs of its members.

Federal Default Standard—Time and Distance

Again, as stated in previous comments, the AMA is very supportive of the use of quantitative standards to measure network adequacy and is very pleased that CMS is proposing a default requirement for QHPs in Federally-facilitated Exchanges (FFE) that incorporates such standards. However, we are again concerned that using only a single quantitative measurement—e.g., a time and distance standard—is not

sufficient to ensure a network is adequate in number and types of providers or is providing access without unreasonable delay. We strongly encourage CMS to, at a minimum, use provider/enrollee ratios in addition to time and distance standards to ensure that the appropriate quantity of providers is available in a network.

While we support CMS' efforts to develop time and distance standards for primary and specialty care, the AMA is concerned that the list in Table 2.1 in terms of the specialties proposed is incomplete. Commonly accessed specialties such as psychiatry, neurology, dermatology, ophthalmology, orthopaedic surgery, pain medicine, and many more are missing from the list. Additionally, separate standards for pediatric specialists are absent, potentially preventing the needs of children from being adequately addressed.

Also, in order to better address coordination within a network between participating providers and participating facilities, we urge CMS to incorporate standards for emergency medicine, radiology, pathology, anesthesiology, trauma surgery, and other hospital-based specialties, and to align those standards with the hospital standards. This could help CMS identify where there are inadequate numbers of hospital-based physicians in a plan's network and help address out-of-network billing when a patient is cared for at a participating hospital.

While understanding and appreciating the complexity of identifying the appropriate specialty areas for which to create standards, we urge CMS to work to expand the list to ensure access to appropriate care. The AMA is ready to work with CMS to help in this effort, as we greatly value the direction CMS is taking with regard to quantitative measurements.

In terms of the time and distance standards proposed, we offer the following suggestions:

- The gynecology (OB/GYN) standard should be the same as the primary care standard. While a broader standard may be appropriate for the Medicare Advantage (MA) population on which we understand this measure is modeled, the QHP population likely requires greater access to this type of care. In fact, many in the QHP population will utilize OB-GYNs as their primary care providers.
- Similarly, while we appreciate CMS' efforts to adapt MA standards to reflect the QHP population, we suggest that the (general) pediatric standards be the same as the primary care standard.
- We encourage CMS to adopt a standard for outpatient dialysis that is at least as strong as the MA standard. A discrepancy between QHPs and Medicare with respect to access to dialysis facilities could discourage End-Stage Renal Disease patients from enrolling in QHPs, even when enrollment is in their best interest.

The AMA also asks CMS to clarify that these federal standards apply to the lowest cost-sharing tier of any tiered network. The AMA is very concerned that tiered networks can be structured in ways that potentially discriminate against those with more health care needs by placing certain providers in higher cost-sharing tiers. Additionally, network requirements may be circumvented by treating all tiers as a single network, despite the access issues that result for patients from experiencing higher cost-sharing

with providers in higher tiers. Therefore, it is important that CMS evaluate networks at the lowest cost-sharing tier to ensure appropriate access for all patients.

With regard to the justification process proposed by CMS for those plans that do not meet the federal requirements, we urge CMS to require that these plans document how they will ensure access to in-network care.

Finally, CMS states that it will continue to monitor network adequacy throughout the year. The AMA is very supportive of such efforts. We specifically ask that CMS require plans to report to CMS when changes to their network would impact their ability to meet federal standards, or when changes to their plan population could impact timely access to care. Upon such changes, we ask that CMS reevaluate the plan's ability to meet the network adequacy requirements.

Network Transparency

The AMA strongly supports CMS' proposal to classify the breadth of the network to provide transparency for patients shopping for plans that meet their needs. Understanding that measuring the breadth of a network is a new endeavor, and that potential improvements to the methodology may be made over time, we offer the following suggestions:

- In terms of the provider categories that CMS intends to focus on to measure breadth of the network, the AMA suggests that this list is too limited. Specifically, we encourage incorporation of commonly accessed specialties, given that a network could appear quite broad while providing limited access to specialty care under the current methodology.
- It is important to determine breadth relative not just to other QHP networks in a specific geographic area, but relative to all provider networks in the area. Some states have limited choices on the exchange that do not include broad networks or networks that provide coverage for out-of-network care. In such situations, the AMA believes it is more important that patients understand that all of their QHP options may be in limited narrow networks, rather than purchasing a plan that appears broad in relation to other QHPs in the area, but is still quite limited.
- We also believe it is important that when calculating the "Provider Participation Rate," all available providers in the area in a particular category are used in the denominator, rather than only QHP providers. Limiting the denominator to only QHP providers may skew the appearance of a network and could create incentives to all insurers in an area to limit their contracts with providers.
- Finally, the AMA suggests that the labels being proposed to identify network breadth are potentially confusing to patients and could lead to patients purchasing networks that do not meet their needs. The AMA encourages CMS to instead use terms such as "narrow," "average," and "broad" to describe the breadth. These terms are regularly used to describe networks currently and would be more easily understandable to patients.

Prescription Drugs (Chapter 2, Section 11)

The AMA strongly supports efforts by CMS to identify if and when a network benefit may be designed in a discriminatory fashion, including a prescription drug benefit. We agree that an outlier analysis is a good way to assess potentially discriminatory formularies, comparing them to formularies at both the state and national levels. Additionally, a higher than average use of protocols such as step therapy or prior authorization for specific classes or categories of drugs could indicate a discriminatory drug benefit and we support CMS' proposal to evaluate the use of these programs.

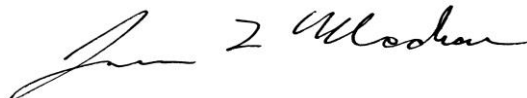
CMS states that it will review each plan's drug coverage to ensure treatment of bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia. The AMA strongly urges CMS to add substance use disorder to this list to reflect the need for treatment options and the growing potential for discrimination in benefit design against this population.

We also strongly support CMS' additional focus on formulary tiering, recognizing that placing a class or category of drugs on a high cost-sharing tier can essentially have the same access or steering effect on patients as failing to include the drugs in the formulary at all. This adverse tiering can certainly be an indicator of a discriminatory design.

Finally, we urge strong enforcement of these requirements at the state and federal levels. We appreciate CMS' urging of states performing plan management functions to implement this type of review of plans, but we suggest that if states do not implement such review, CMS should strongly enforce these provisions.

Thank you for considering the AMA's comments. If you have any questions or concerns, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD