AMA
AMERICAN MEDICAL ASSOCIATION

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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the *Advance Notice of Methodological Changes for CY 2015 for MA Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter*. The AMA welcomes and strongly supports the Centers for Medicare & Medicaid Services' (CMS) proposal to institute a new procedural rule to facilitate CMS oversight of MA plans' compliance with access requirements when a significant change to a provider network is contemplated. We urge CMS to proceed with and finalize this proposal.

CMS considers significant changes to provider networks as those that affect, or have the potential to affect, a large number of the MA plan's enrollees. The agency is soliciting comments on whether a uniform standard or threshold that constitutes a "significant" change may be identified and applied globally. The AMA recommends that plans be required to inform CMS when the percentage of physicians to be removed from the network(s) exceeds 10 percent.

CMS proposes to require that MA plans notify their CMS Regional Office no fewer than 90 days prior to the effective date of a planned termination. The AMA supports this requirement as a minimum threshold, but suggests that a best practice would be an even earlier notification, such as 120 days. Such notification would allow plans and CMS Regional Offices to coordinate in making sure that affected patients and physicians receive timely notification of network changes, as well as allowing CMS to assess whether the plan will continue to meet required network standards if the planned network changes are implemented. Engaging CMS early in the process would also enable CMS to help the plan prevent and address potential patient and physician concerns.

In many communities throughout the U.S., network terminations made for the 2014 plan year caused very serious disruption to longstanding patient and physician relationships, physician referral networks, and

even emergency department coverage. MA plan sponsors did not provide adequate notice to patients in advance of the Annual Election Period that their physician would no longer be a part of the plan's network this year. The new procedures that CMS has proposed could help mitigate the problems that patients and physicians experienced during this past Annual Election Period in the future.

CMS also states its expectation that MA plans would have validated that their networks meet Medicare access standards prior to submitting network data to CMS, and it proposes that plans submit to CMS, upon request, a written plan that provides a detailed description of the steps the plan will take to ensure that affected patients are able to locate new physicians that meet their individual needs. This plan would describe how continuity of care would be maintained for affected patients. The AMA applauds this requirement in the proposed Call Letter.

Under its existing guidance, when CMS determines that an impending network change would not meet Medicare access standards, the plan may be required to augment its network by contracting with additional physicians or allowing members to access care from out-of-network physicians at in-network cost-sharing amounts. CMS notes that it may also be necessary for plans to allow care to continue to be furnished on a transitional basis by physicians who have been terminated from the network in order to adequately address continuity of care needs for affected patients. The AMA strongly supports this guidance and appreciates the agency's effort to underscore its importance.

CMS also notes that its experience has shown that a beneficiary notification period of longer than 30 days is important to furnish patients with needed assistance in selecting new physicians, manage continuity of care for those undergoing medical treatment, and to maintain patient satisfaction. CMS expresses its view that a longer notification period would afford enrollees additional time to make any needed transitions. The AMA agrees that a 30-day time period is too short and that CMS should use the notice and comment rulemaking process to require more than 30 days advance notice to enrollees.

CMS believes that as a best practice, MA plans should include the following information in notices to enrollees in addition to the mandatory identification of the provider(s) being terminated from the network:

- Names and phone numbers of in-network providers that enrollees may access for continued care;
- Information regarding how enrollees can request continuation of ongoing medical treatment or therapies with their current providers; and
- Customer service number(s) where answers to questions about the network changes will be available.

These requirements are an excellent beginning. We note, however, that MA enrollees whose physicians were terminated from their plan last year were faced with enormous confusion about their medical care. No patient should be forced to switch physicians in the middle of their treatment plan. It should be assumed that patients will be given the ability to continue with their current physician(s) until their treatment plan is completed, unless a patient opts out of this continuity of care plan. In addition, patients with chronic conditions often choose a plan based on whether their physicians are in-network, so procedures should be adopted to address these patients' needs as well.

The AMA also welcomes the policy change that CMS is contemplating that would limit plans' ability to terminate physician contracts without cause at any time during the year. Annual Election can be a confusing time for patients facing decisions about health plans, prescription drug plans, and supplemental

coverage. Allowing plans to make wholesale changes to their networks during Annual Elections that take effect early in the succeeding year magnifies this problem significantly. The AMA urges CMS to require, through rulemaking, that enrollees be notified prior to the start of the Annual Election Period regarding any network changes that will be effective on or after January 1st of the following year, just as Part D plans are already required to do with regard to formulary and pharmacy changes for succeeding years. We strongly encourage CMS to make these policy changes effective for the Annual Election Period for 2015, which begins on October 15, 2014.

The AMA also supports the proposal to strengthen the current requirements regarding plans' responsibilities to notify enrollees of network changes in their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) materials, which are provided to all enrollees each fall. These modifications will require MA plans to explicitly notify enrollees of their rights should a plan make changes to their provider network during the year. In addition, CMS states that it will verify that plans include language regarding such changes in their ANOC and EOC if they make changes to their network during or shortly after the Annual Election Period.

Finally, the AMA strongly supports the proposal to afford physicians more than 60 days notice of a contract termination. A longer period would give physicians sufficient time to exercise their appeal rights and for the appeals process to conclude, perhaps before affected enrollees are notified of the change. Using current timeframes, there are instances in which the notice of a termination reaches the affected enrollees while the physician is appealing the termination.

We thank you for considering our comments.

Sincerely,

James L. Madara, MD