July 27, 2015

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS -2390P (Medicaid and Children's Health Insurance Program (CHIP); Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.

Dear Acting Administrator Andrew M. Slavitt:

We, the undersigned coalition of hospital based physician specialties, are jointly submitting comments to CMS on the above captioned rule on a matter of importance to all of our respective members and the millions of patients we serve.

The coalition of hospital-based physician specialties has reviewed the proposed rule and found the network adequacy section of the rule 6.a. "Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards (§ 438.206, § 438.207, § 438.68, §440.262) to be insufficient to ensure that patients enrolled in these Medicaid contracted Managed Care Organizations (MCOs), Pre-Paid Inpatient Health Plans (PIHPs) and Pre-Paid Ambulatory Health Plans (PAHPs) are able to access the services of in-network hospital based physicians, at participating facilities and hospitals.

For this proposed rule, CMS contemplated use of "time and distance" as standards to assess whether patients had reasonable access to in-network physicians and services. This particular standard has no applicability to address and remedy the problem of health plans contracting with hospitals and facilities without a sufficient number of hospital-based specialist physicians at these facilities. Furthermore, state network adequacy standards set forth in law and regulation governing state licensed health plans have been woefully inadequate. As a consequence, in the non-governmental payer market, patients have been involuntarily reliant upon out-of-network providers for hospital based services, with concomitant out-of-pocket costs for the patient that exceed deductibles, copayments and coinsurance amounts that the patient would pay had the physician service been in-network under a contract with the health plan. The financial exposure of patients in this scenario can be attributed to the failure of state laws and regulations for network adequacy that has allowed health plans to market insurance products that do not provide robust networks of contracted physician specialists at in-network hospitals and facilities.

As states now scrutinize their own network adequacy criteria and, are influenced by network adequacy provisions at the federal level, we believe it is important for CMS to establish a paragon standard in this area that will promote robust in-network provision of physician services at in-network hospitals and facilities, regardless of governmental or non-governmental coverage. Doing so will protect patients, minimize their costs for health care services in the commercial insurance market and in the state and federally sponsored health plan exchanges. The imperative in this regard is underscored by the CMS stated "underlying goal to align Medicaid managed care standards with other public programs where appropriate" including use of the "network adequacy standards applicable under the Marketplace and MA program to inform our proposed rule."[i]

Notably, the 2011 CMS Medicare Advantage Network Adequacy Criteria included: "An additional requirement concerning acute inpatient hospitals is that applicants demonstrate that they have contracted with the anesthesiology, emergency medicine, pathology and radiology groups providing these hospital-based services at each contracted acute inpatient hospital." Furthermore, our coalition has proposed substantively similar requirements, as we are proposing herein, to the National Association of Insurance Commissioners (NAIC) as part of their deliberations on revisions to their 1996 managed care plan network adequacy model act (#74).

Accordingly, in order to promote standards of network adequacy that ensure "reasonable access" to in-network physician specialists at participating hospitals and facilities, we urge CMS to include in this rule an additional requirement under §438.68 that:

> **Proposed New Requirement Under §438.68**
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> MCOs, PIHPs, and PAHPs must demonstrate that they have contracted with physicians who specialize in anesthesiology, pathology, radiology and hospitalists in sufficient numbers at any in-network facility or in-network hospital included in such plan so that patients enrolled in these plans have reasonable access to these in-network physician specialists.

Thank you for your consideration of our proposed amendment to the proposed rule. Should you have questions or need additional information, please contact Barry Ziman, Director of Legislation and Political Action, College of American Pathologists, 202-354-7117, or bziman@cap.org. Thank you for your consideration of these comments.
Sincerely,

- American College of Radiology
- College of American Pathologists
- American Society of Anesthesiology
- Society of Hospital Medicine

[i] CMS-2390-P, p. 174