



Sound Policy. Quality Care.

January 27, 2022

Chiquita Brooks-LaSure, JD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Ms. Brooks-LaSure,

The Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians across 15 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care through the advancement of sound health policy. On behalf of the undersigned members, we write to provide feedback on the aforementioned proposed rule.

Prohibition on discrimination (§ 156.125)

The Alliance supports the Agency’s proposal to revise its regulations to ensure that benefit designs, particularly benefit limitations and plan coverage requirements, are based on clinical evidence.

Adverse tiering that limits access to prescription drugs for chronic health conditions or highly specialized surgical care are perfect examples of discriminatory benefit designs that specialists contend with frequently. As we’ve shared before, in the prescription drug context, formulary decisions are almost exclusively influenced by financial considerations rather than clinical data, especially when it comes to specialty medicines. This is concerning for patients who rely on life-saving medications for chronic and terminal illnesses, including cancer, rheumatoid arthritis, age-related macular degeneration, heart disease and many other diseases diagnosed, treated, and managed by specialists.

In fact, the Medicare Payment Advisory Commission, which advises lawmakers on Medicare payment, recently shared data on the impact of heavily-rebated drugs in Medicare Part D, highlighting the benefit of high-priced, rebated drugs for plans, which accrue financial rebates, at the expense of taxpayers, manufacturers, and enrollees.¹ These sentiments apply to the Affordable Care Act (ACA) Marketplace plans as well.

The Alliance has previously weighed in with concerns that access to new, innovative therapies, many of which have changed the spectrum of care in certain disease areas, remain severely hindered because of plans’ emphasis on high-cost, high-rebate medicines. Because of these practices, patients and providers must deal with even more aggressive utilization management practices, such as step therapy and complex prior authorization requirements, to access “non-preferred” medications. Even then, costs to

¹ <https://www.medpac.gov/wp-content/uploads/2021/10/Part-D-status-MedPAC-Jan22.pdf>

consumers may be higher because the medication is on a higher tier, thus subject to increased cost-sharing.

In light of these concerns, we strongly support the proposal to require clinical evidence as the basis for nondiscriminatory benefit design.

Network Adequacy (§ 156.230)

The Alliance strongly supports the agency's proposal to resume its own evaluation of network adequacy across Marketplace plans. However, we urge key improvements to ensure robust consumer access to specialty medical care.

The ACA requires Marketplace plans to include an “adequate network of primary care providers, specialists, and other ancillary health care providers,” and for the Secretary of Health and Human Services (HHS) to establish criteria that, among other things, ensures a sufficient choice of providers. Despite this mandate, Marketplace plans have gone “unchecked,” contributing to increasingly narrow provider networks exacerbating Centers for Medicare & Medicaid Services (CMS) concerns about patients encountering providers that plans have not included in their plan networks.

Insurers argue that “narrow networks” are an essential component to market stabilization that allows them to reduce their costs and, arguably, keep premiums and deductibles low for consumers. However, the shortcomings of limited provider networks are multi-fold and were immediately observed in specialty medicine, to wit:

- Specialists were eliminated or blocked from plan participation;
- Consumers met insurmountable obstacles accessing needed specialty care; and
- Growth in “surprise bills” drove lawmakers to legislate new patient protections as part of the *No Surprises Act*.

To meet the ACA mandate and address network adequacy concerns, the agency first adopted quantitative standards for evaluating provider networks at the federal level. However, succumbing to industry pressure, CMS adopted a new approach that relied on assessments by states and accrediting organizations. As expected, most states were ill-prepared to ensure network adequacy — which continues to be evidenced by the [limited number of states that have adopted network adequacy standards](#), such as the [National Association of Insurance Commissioners \(NAIC\) Health Benefit Plan Network Access and Adequacy Model Act \(#74\)](#). Similarly, accreditors lack robust standards for access to specialists and — more importantly — have no authority or enforcement mechanism to compel plans when they fail to meet network standards.

Collectively and individually, the Alliance and its member societies have expressed concerns about the adequacy of provider networks across Marketplace plans and the impact on consumer access to care, a problem that has worsened in recent years. Specialty and subspecialty physicians continue to report that plans frequently exclude or block them from network participation. For example, plans have misapplied population-based performance metrics, holding specialists accountable for care they cannot control. In addition, they have established inappropriate “peer-groups,” leading to inaccurate “apples-to-oranges” comparisons.

Moreover, a close review of the Qualified Health Plan (QHP) Quality Rating System (QRS) shows that the measures to which plans are held are not generalizable to most specialists and subspecialists, nor do they align with physician-level quality measures reported under the agency’s other quality improvement programs, such as the Merit-Based Incentive Payment System. We see this as an area where

improvement is critical, particularly given that QHPs rely on claims and administrative data to generate physician performance scores, which continues to be problematic.

Contributing to “narrow networks” is the agency’s own failure to require plans to report data on the full range of specialty types when submitting their application(s). A close review of [CMS’ QHP Application](#) (see screenshot below) reveals that several specialists — *and all subspecialists* — are excluded from the agency’s evaluations of whether a plan has an adequate network.

**Screenshot of “Specialty Type” identified in
CMS’ 2022 QHP Application/Network Adequacy Template**

Instructions for populating the Specialty/Facility Types without using the drop-down menu	
The lists below show the specialty/facility & pharmacy types that can be entered in the ECP/Network Adequacy template. Column C shows the Individual Provider (MD/DO) Specialty Types. Column D shows the Facility, Pharmacy, and Other Non-MD/DO Specialty Types. Both sets of Specialty Types are allowed to be entered for a provider. If you would like to enter more than 1 specialty/facility type for a record, please comma separate each type. For example, if you would like to assign 001 General Practice and 002 Family Medicine specialty types to a provider, please enter the types as “001 General Practice, 002 Family Medicine”. Entering multiple specialty/facility types using any other convention will result in a validation error. The same comma separation technique can be used to assign multiple Network IDs to the same provider. For example, an issuer in Virginia with 3 Network IDs could assign network 1 and network 3 to the same provider by entering “VAN001, VAN003”.	
Individual Provider (MD/DO) Specialty Types	Facility, Pharmacy, and Other Non-MD/DO Specialty Types
001 General Practice	Pharmacy
002 Family Medicine	040 General Acute Care Hospital
003 Internal Medicine	041 Cardiac Surgery Program
004 Geriatrics	042 Cardiac Catheterization Services
005 Primary Care - Physician Assistant	043 Critical Care Services - Intensive Care Units (ICU)
006 Primary Care - Nurse Practitioner	044 Outpatient Dialysis
007 Allergy and Immunology	045 Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
008 Cardiovascular Disease	046 Skilled Nursing Facilities
010 Chiropractic	047 Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
011 Dermatology	048 Mammography
012 Endocrinology	049 Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
013 ENT/Otolaryngology	050 Occupational Therapist
014 Gastroenterology	051 Speech Therapy
015 General Surgery	052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
016 Gynecology (OB/GYN)	054 Orthotics and Prosthetics
017 Infectious Diseases	055 Home Health
018 Nephrology	056 Durable Medical Equipment
019 Neurology	057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
020 Neurological Surgery	061 Heart Transplant Program
021 Medical Oncology & Surgical Oncology	062 Heart/Lung Transplant Program
022 Radiation Oncology	064 Kidney Transplant Program
023 Ophthalmology	065 Liver Transplant Program
025 Orthopedic Surgery	066 Lung Transplant Program
026 Physical Medicine & Rehabilitation	067 Pancreas Transplant Program
027 Plastic Surgery	000 OTHER
028 Podiatry	
029 Psychiatry	
030 Pulmonology	
031 Rheumatology	
033 Urology	
034 Vascular Surgery	
035 Cardiothoracic Surgery	
101 Pediatrics - Routine/Primary Care	
102 Licensed Clinical Social Workers	
103 Psychology	
000 OTHER	
Dental - General	
Dental - Orthodontist	
Dental - Periodontist	
Dental - Endodontist	

Consumers require access to the full range of specialty and subspecialty physicians to ensure their plan has an adequate provider network. When searching for a plan on the Marketplace, consumers tend to focus on whether their routine care providers (e.g., a primary care physician, local urgent care, or a local hospital) are in the network and whether any ongoing medications are on the formulary. Often, consumers do not realize the limitations of their plan’s provider network until they are faced with a critical need for specialty medical care and treatment. Only then do the barriers to specialty care become evident.

We also emphasize the importance of addressing network adequacy as the agency continues to implement provisions of the *No Surprises Act (NSA)* to protect consumers from surprise medical bills. As CMS is aware, not all services are subject to the recently established protections. Where specialists are refused network entry or unfairly dropped from networks, they will be forced to bill for out-of-network services under the NSA’s “notice and consent” provisions, given their inability to negotiate a fair and reasonable contract with plans in the Marketplace. Without guardrails on network adequacy in these plans, CMS is undermining its NSA rulemaking by *increasing* the likelihood that providers will be out-of-

network, which is counter to the goals of the new law. This behavior could be easily mitigated by requiring plans to establish robust networks that include the full range of specialty and subspecialty providers, consistent with the ACA mandate.

Again, we appreciate that the agency is proposing to revert to a federal standard for network adequacy in the Marketplace and agree that alignment with Medicare Advantage plans is critical, particularly as access to specialty care remains challenged in that market as well. To ensure Marketplace consumers have meaningful access to specialty care, ***we urge CMS to finalize its proposal to restore federal network adequacy standards, as well as implement the following recommendations we've made over the past several years:***

- ***Require Marketplace plans to account for all specialty and subspecialty designation taxonomy codes to meet network adequacy requirements;***
- ***Require Marketplace plans to provide reasonable notice regarding termination of a provider's in-network status, detailed information on the cause for termination, and options for re-entering the network;***
- ***Require Marketplace plans to maintain accurate, real-time provider directories; and***
- ***Develop Quality Rating System (QRS) measures that tie network adequacy to health plan quality scores.***

With respect to the use of time and distance standards, appointment wait times, tiered networks and telehealth services to set quantitative standards, we urge CMS to confer with stakeholders, such as the NAIC, on appropriate metrics that would yield the most robust access to providers, including specialists. We also urge the agency to ensure various circumstances are considered when setting quantitative standards, to include when patients may require various specialty and subspecialty providers to deliver a comprehensive set of services to treat and manage disease (e.g., patients that require a team of physicians from various medical and surgical specialties to diagnose, treat and manage breast cancer).

Importantly, and consistent with our prior sentiments, we strongly support the agency's statement that telehealth services should not be counted in place of in-person service access for the purpose of network adequacy standards. While telehealth continues to be an essential means of increasing access to care — including specialty care — as evidenced during the COVID-19 public health emergency, the full range of specialty care and treatment that a given consumer may need could not be fulfilled through telehealth. For example, a patient with rheumatoid arthritis that requires a physician-administered drug infusion to manage their disease, a patient with skin cancer that requires Mohs micrographic surgery, or a patient with breast cancer that requires post-mastectomy breast reconstruction, could not receive the full range of treatment needed via telehealth alone.

We appreciate the opportunity to comment on these crucial issues. The Alliance would welcome the opportunity to meet with you to discuss these issues in more detail. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American College of Osteopathic Surgeons
American College of Mohs Surgery

American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society