Sound Policy. Quality Care.

November 27, 2017

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

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Ms. Verma,

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians from thirteen 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 express ongoing concern with network adequacy in Marketplace plans and other issues.

Qualified Health Plan Certification (Subpart C)

Similar to requirements in CMS' Market Stabilization regulations for 2018 Qualified Health Plans (QHPs), CMS is proposing to rely on States and private accrediting organizations to assess network adequacy of Marketplace plans. Specifically, CMS proposes to rely on State reviews for network adequacy in States in which a Federally-Facilitated Exchange (FFE) is operating, provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation. In States without the authority or means to conduct sufficient network adequacy reviews, CMS would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity, i.e., the National Committee for Quality Assurance (NCQA), URAC (formerly the Utilization Review Accreditation Commission), and Accreditation Association for Ambulatory Health Care (AAAHC). Unaccredited issuers would be required to submit an access plan as part of the QHP Application that demonstrates that the issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. Finally, CMS proposes to coordinate with States to monitor network adequacy through complaint tracking. ***We remain deeply concerned about these proposals.***

Access to specialty medical care is an ongoing challenge for consumers in Marketplace plans. Often, consumers do not realize the limitations of their plan's provider network until they are faced with a critical need for specialty medical services and the providers who deliver them. Only then do the barriers to specialists and subspecialists become apparent. As a result, many patients forego important, medically necessary specialty care because the obstacles to acquiring treatment are too significant. Some practices have patients contact them to "negotiate" cash payment for services because an in-network provider is more than 100 miles away and they do not have out-of-network benefits. In such cases, the patient's insurance is useless: it pays nothing, nor does it even provide the benefit of an insurer-negotiated rate.

Specialty and subspecialty physicians report that plans frequently exclude them from participation in their networks based on inappropriate performance metrics, which further limit access to care. Often, the population-based measures that plans hold specialists accountable for are not related to care they can control. A review of the QHP Quality Rating System (QRS) shows that the measures plans are held to are not generalizable to most specialists and subspecialists, nor do they align with physician-level quality measures reported under CMS' quality improvement programs, such as the Merit-Based Incentive Payment System (MIPS). We see this as an area where improvement is critical, particularly given that QHPs, much like Medicare Advantage (MA) plans, rely on claims and administrative data to generate physician performance scores, which are used to justify eliminating them from networks. For subspecialty physicians, the challenge may be even greater, as we understand that QHPs – like MA – do not stratify physicians' subspecialties to make appropriate and fair comparisons, an issue that Alliance members have raised previously.

Further, we do not believe States are prepared to ensure network adequacy, which is evidenced by multiple State legislative proposals aimed at out-of-network or "surprise" medical bills – an issue that is directly related to the adequacy of an insurer's network rather than specialists' willingness to negotiate for fair payment with health plans. To date, a limited number of States have adopted the NAIC Model Act, but its adoption alone is not a guarantee that consumers will have access to the full range of "specialists," (which includes subspecialists) as defined in the model law.

Finally, accreditation organizations, while valuable, have no legal authority, no enforcement capability, and are not accountable to the public. As a result, they cannot hold insurers liable if and when consumers cannot access the specialty medical care they require. While imperfect, CMS is engaged in monitoring network adequacy through its review of MA plans' provider directories, which is experience that could be leveraged in the Marketplace.

Essential Health Benefits (EHB) Package

CMS is proposing to provide States with additional flexibility in their selection of an EHB-benchmark plan for plan year 2019 and later plan years. For plan years further in the future, CMS is considering establishing a Federal default definition of EHB that, according to the agency, would "*better align medical risk in insurance products by balancing costs to the scope of benefits*." As explained by CMS in the rule, *"[t]he benefits of a Federal default could outweigh the potential impact on flexibility afforded to States, but we are also considering allowing States continued flexibility to adopt their own EHB-benchmark plans, provided they defray costs that*

exceed the Federal default…We understand that in developing this type of default definition there are trade-offs in adjusting benefits and services. For instance, as part of this approach, we could *establish a national benchmark plan standard for prescription drugs that could balance these tradeoffs and provide a consistent prescription drug default standard across States."*

The concept of a Federal default set by the Administration is concerning. We have significant concerns about the impact of this approach on access to specialty medical care, particularly given that the Administration is entertaining a national benchmark standard plan for medicines. A national benchmark could lead to greater federalization and, as a result, less provider and patient choice and access of life saving medications. This is particularly true because, in the experience of our members, formulary decisions too often can be influenced by financial considerations rather than clinical data**.** This is concerning for patients who rely on life-saving medications for chronic and terminal illnesses, including cancer, rheumatoid arthritis, age-related macular degeneration (AMD), heart disease and many other diseases that are diagnosed, treated, and managed by specialty and subspecialty physicians. In addition, we are concerned that access to new, innovative therapies, including new biologics and biosimilars, many of which have already changed the spectrum of care in certain disease areas, will be severely hindered. Further, we are concerned that a national benchmark could force patients and providers to deal with more even more aggressive pharmacy benefit manager (PBM) utilization management practices, such as step therapy and complex prior authorization requirements, which can limit patient choice and access.

Patients and their physicians are in the best position to determine the most appropriate pharmaceutical therapies for a multitude of diseases based the clinical evidence and the clinician's expertise and medical judgement; not the federal government. ***We oppose efforts to establish a national benchmark plan standard for prescription drugs.***

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We appreciate the opportunity to provide comments on the aforementioned issues of importance to the Alliance. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons