



Sound Policy. Quality Care.

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April 6, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-4190-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Submitted online via regulations.gov

**Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4190-P)**

Dear Administrator Verma:

On behalf of more than 100,000 specialty physicians from 14 specialty and subspecialty societies, and dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care, the undersigned members of the Alliance of Specialty Medicine (the "Alliance") write in response to proposals outlined in the aforementioned proposed rule.

### Network Adequacy

We are deeply concerned with CMS' proposals that would codify certain specialties for purposes of network adequacy. The Alliance membership is comprised of a number of subspecialty physicians, many of whom are not counted in current network adequacy metrics. We have repeatedly encouraged CMS to require use of a more robust set of physician specialty types (i.e., the Healthcare Provider Taxonomy Code Set) when calculating Medicare Advantage (MA) network adequacy, given many subspecialties have faced challenges participating in MA networks. For example, Mohs surgeons were altogether excluded from MA networks in some areas of the country. ***We ask CMS to reconsider its proposal to codify a list of provider specialty types that would exclude any medical specialty or subspecialty.***

In addition, while the Alliance is deeply supportive of efforts to improve access to telehealth providers, particularly given the important role of these and other virtual care services during the current COVID-19 pandemic, ***we urge CMS to ensure in-person services are prioritized in determining network adequacy in Medicare Advantage.*** We understand CMS is looking to incentivize MA plans to include more telehealth providers in their networks by offering bonus points, a laudable goal. However, we cannot emphasize enough that in-person availability is essential in caring for beneficiaries, and telehealth services should never replace access to in-person care with respect to network adequacy.

## SUPPORT ACT Implementation for Opioid Prescribing

As CMS implements important aspects of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, we are particularly concerned that patients treated by specialty physicians will be able to continue to receive the care that they need. We note that CMS has asked for public comment on reasonable measures to assess inappropriate prescribing of opioids and we are eager to assist CMS as the agency establishes its policy to direct Medicare Advantage (MA) plans to help identify patterns of inappropriate prescribing while avoiding unnecessary harm and suffering for patients. The proposed definition of “inappropriate prescribing of opioids” states that patterns of abuse will be established based on facts considered by plan sponsors. Our patients, some of whom are experiencing post-operative pain or complex chronic pain, have unique needs and their care is highly individualized. **We believe a peer physician from the same specialty, after considering specific patient needs, is most qualified to determine whether opioids have been prescribe appropriately.** In addition, **we urge the agency to remove coding and reimbursement barriers to innovative, non-opioid pain treatment, including other pharmacologic and non-pharmacologic device-related options.** CMS policy should focus on the need to improve pain management practices beyond the narrow focus of limiting the prescribing of opioid analgesics and our specialty society members are eager to lend their expertise to help the agency in this task.

## Second Specialty Tier in Part D

Currently, Part D sponsors are permitted to include one specialty tier in their plan design. CMS allows Part D sponsors to exempt drugs placed on the specialty tier from their tiering exceptions process. CMS now proposes to allow Part D sponsors to establish up to *two* specialty tiers and exempt Part D drugs on these tiers from exceptions.

Physicians have often addressed the issues related to aggressive tiering by insurers and pharmacy benefit managers. Often, tier placement has little to do with the clinical profile of the actual medicine, but rather with the negotiations between the pharmacy benefit manager (PBM) and the pharmaceutical manufacturer.

Allowing PBMs and insurers another option for tiering products provides them with more power to extract price concessions – which may initially sound positive, but CMS itself has, in past rulemaking, highlighted the issues with the existing treatment of price concessions in Part D. First, failure to reflect price concessions in negotiated prices at the point of sale increases costs for Medicare by pushing beneficiaries through the benefit into catastrophic coverage more quickly, which shifts more of the total spend onto the government. Second, CMS’ own analysis has found that, in recent years, plans and PBMs have consistently been in actual receipt of more direct and indirect remuneration, including price concessions, than they project in their bids for the year. This contributes mostly to profits for the plans, not to lower premiums for beneficiaries. Finally, the current freedom plans have with regard to whether to classify their price concessions as DIR results in bids and plan options that are not truly comparable.

In light of the above, it is unclear how simply providing PBMs with additional mechanisms to do more of the same will help beneficiaries or the Medicare program. This is especially true when their utilization management tactics already negatively impact patient care in Part D today. As such, **we oppose the proposal to create a second specialty tier in Part D.**

## Quality Rating System

The Alliance has made a number of suggestions that would improve the Quality Rating System (QRS) in ways that would emphasize beneficiary access to specialty care, for example, the establishment of a stars measure that would award points to MA plans that maintain an adequate network of specialty and subspecialty physicians. We have also supported the development of a survey of physicians experiences with MA plans, an idea that CMS discussed in a prior rulemaking cycle. Toward that end, ***we ask CMS to reconsider these measure concepts and propose them in the future rulemaking***, particularly given the agency's current proposal that would increase the weight of patient experience/complaints and access measures from a weight of 2 to 4, ***an increase that we support***.

Moreover, ***we strongly believe that patient and physician experience measures, and beneficiary complaints, should have a significant impact on a MA plan's star rating and associated quality bonus payment (QBP)***. Otherwise, plans are unlikely to take action to improve stakeholder experiences and meaningfully address complaints.

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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](mailto:info@specialtydocs.org).

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery  
American Association of Neurological Surgeons  
American College of Mohs Surgery  
American College of Osteopathic Surgeons  
American Gastroenterological Association  
American Society of Cataract and Refractive Surgery  
American Society for Dermatologic Surgery Association  
American Society of Retina Specialists  
American Urological Association  
Coalition of State Rheumatology Organizations  
Congress of Neurological Surgeons  
North American Spine Society