

January 26, 2016



The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Johnny Isakson  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

*American Academy of Dermatology Association*  
Excellence in Dermatology™

Re: Bipartisan Chronic Care Working Group Policy Options Paper

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of the 13,500 U.S. members of the American Academy of Dermatology Association (Academy), the Academy appreciates the opportunity to comment on the Bipartisan Chronic Care Working Group Policy Options document. We recognize the importance of the overarching issues the Committee highlights in its paper including: developing and implementing policies designed to improve disease management, streamlining care coordination, improving quality, and reducing Medicare costs. We commend you and the Committee for your continuing leadership to address this challenging component of our health care system.

Dermatologists are often the primary coordinators for patients with chronic diseases of the skin. In many instances, dermatologists provide all of the necessary care for a patient. Dermatologists diagnose and treat more than 3,000 diseases including many chronic inflammatory, multi-system, disabling and life-threatening conditions including skin cancer, which 1 in 5 Americans will develop in their lifetime, and psoriasis and psoriatic arthritis, which collectively affects 3.2% of the population. Dermatologists are essential in coordinating the care of patients with chronic diseases and are a valuable team member of the care coordination model.

### **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage (MA) Enrollees.**

The Academy supports giving MA plans flexibility, with reasonable parameters, that helps establish a benefit structure that varies based on chronic conditions of individual enrollees. Specifically, the Academy is pleased to respond to the following two policy proposals:

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- Reduction in cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease.
- Adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic condition or prevent the progression of the chronic disease.

Regarding the reduction of cost sharing, it is important that patients not be overwhelmed with large medical bills that deter them from seeking necessary care. Like many other physicians and specialties, the Academy is concerned about the rising costs of treatment and its effect on patients. A recent study in JAMA Dermatology found that “of 19 [dermatologic] brand-name drugs analyzed, the retail prices of 7 drugs more than quadrupled” between 2009 and 2015. Additionally the authors found that “selected generic drugs surveyed in 2011 and 2014 also increased a mean of 279%.”<sup>1</sup>

Due to increasing drug costs, some insurers are moving life-improving medications (such as biologics) into higher level “specialty tiers,” placing medically necessary treatments out of reach for average Americans. The Committee is to be commended for exploring reductions in cost-sharing, which could help address trends that threaten to restrict or interfere with a patient’s medically necessary use of medications. To this end, the Academy supports legislation such as H.R. 1600, the Patients’ Access to Treatments Act, which would limit cost-sharing requirements applicable to drugs in a non-preferred drug tier. This legislation is one avenue that could begin to accomplish the policy proposal of reducing cost-sharing.

The Academy also believes an important factor in improving outcomes for Medicare patients living with multiple chronic conditions is access to an adequate network of providers and sustained access to their network of physicians during the benefit year.

Patients expect and should receive accurate and up-to-date information when they are enrolling in a plan and attempting to identify a physician to provide needed care. However, recent studies published by both JAMA Dermatology and the California Department of Managed Healthcare found that only 50% of physicians listed in a given plan’s directory were actually accepting the listed plan and new patients. These findings indicate patients are being provided with misleading and inaccurate provider directories when making important health care choices. If a patient selects a plan because a physician with whom they have an existing relationship was listed in network in error, the Academy believes that the patient should have an opportunity to select a new plan that includes that physician. Patients with chronic conditions often have long-standing relationships with their network of physicians and specialists. To force patients away from these relationships due to lack of accuracy in a plan’s provider network is certainly not in the best interest of the patient.

The Academy believes provider networks exist to serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise. During open season patients, especially those with chronic conditions, frequently choose their plan based on the provider network available to them during the plan selection period. Once the patient selects a plan, the patient is locked into that plan for

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<sup>1</sup> Miranda E. Rosenberg, BA; Steven P. Rosenberg, MD. *Changes in Retail Prices of Prescription Dermatologic Drugs From 2009 to 2015*. JAMA Dermatology.

the full year. Should a plan terminate a physician from its network “without cause”, the Academy believes that impacted patients should retain access to that physician until the next benefit year when the patient has an ability to select a new plan with a provider network that best meets their health care needs. Cutting off patients’ access to their physician mid-year can undermine patients’ ability to receive care from the physicians that know them and their health care needs best.

CMS utilizes a Health Service Delivery (HSD) table to determine network adequacy for Medicare Advantage plans. The HSD Table calculates the ratio of physician to covered persons a plan must meet in order to achieve CMS’s definition of network adequacy. The Academy has concerns that CMS is not using Full-Time Equivalents (FTE’s) when evaluating the physician-to- covered-persons ratio. It is common for physicians, particularly in rural regions, to practice part-time in multiple facilities to increase patient convenience. Failure to appropriately determine the provider FTE within a network could lead to an inaccurate ratio calculation, resulting in insufficient access to care for patients enrolled in that plan. The Academy urges the Committee to recommend considering the availability of full-time physicians rather than the facility’s operating hours. Physicians working part-time could skew the accuracy of physician availability.

### **Increasing Convenience for Medicare Advantage Enrollees through Telehealth**

The Academy is a leader in telemedicine and has first-hand knowledge of the benefits that telemedicine can offer patients in gaining access to specialty care. The Academy supports the appropriate use of and payment for telemedicine as a means of improving patient access to the expertise of board-certified dermatologists when certain criteria are met.

The Academy is encouraged by the proposed policy to permit MA plans to include certain telehealth services in its annual bid. The Academy also commends the Committee for highlighting that network adequacy requirements would be neither substituted nor become a pay-for of new telehealth services in MA plans.

In order to ensure patients receive high-quality care, the provision of teledermatology services should include care coordination between the patient’s existing primary care physician—or medical home, and dermatologist with whom there is an established relationship, if one exists. Identifying the patient’s existing primary care physician and dermatologist in the medical record and providing their information to other members of the treatment team is also important so that information about diagnoses, test results, and medication changes are available to the existing care team.

For this proposed policy it is recommended that the MA plans be required to allow telemedicine providers to have the option to choose between or combine two fundamentally different care delivery platforms: 1) Store-and-Forward; and 2) Live Interactive. Dermatology is a visual specialty and thus lends itself to use of store-and-forward technologies for the provision of telemedicine. Currently, CMS has limited reimbursement for store-and-forward telemedicine to Hawaii and Alaska as a demonstration project. The Academy recommends the expansion of this demonstration project to all states.

The Academy also strongly supports patient choice. Therefore, we support the proposed new flexibility for MA plans telehealth services but do not believe they should restrict patients to only use telemedicine services. A patient who is seeking treatment for a chronic condition should be able to choose between an in-person physician or telemedicine encounter. In addition, a

patient who chooses to pursue telemedicine should know the licensure and board certification qualifications of the clinician providing care in advance of the treatment just as one would for in-person care.

### **Providing ACOs the Ability to Expand the Use of Telehealth**

The Academy supports establishing a process by which accountable care organizations (ACOs) participating in Medicare Shared Savings Plans two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology. The Academy recognizes that there are circumstances when access to specialty care is limited or difficult to access on a regular basis. ACOs can bridge this access gap with the utilization of telemedicine by allowing primary care providers to interface with dermatologists in the delivery and management of dermatologic care.

### **Encouraging Beneficiary Use of Chronic Care Management Services/ Improving Care Management Services for Individuals with Multiple Chronic Conditions**

The Academy also commends the Committee for proposing to develop a new high-severity chronic care management code under the Physician Fee Schedule. Patients suffering from, for example, chronic atopic eczema, autoimmune bullous disease, genetic bullous disease, cutaneous cancers, chronic wound care, and many rare and orphan diseases, often require continued care from a dermatologist. The proposed new code would allow for patients suffering from chronic diseases to receive even more comprehensive dermatological care within the care team model.

With the recent development of the new chronic care management code, the Academy also supports the proposal to waive the beneficiary co-payment associated with the current chronic care code as well as the proposed high-severity chronic care code. Increased transparency of coverage options and potential out of pocket costs is essential for both patients and providers to make informed decisions about the course of treatment. Eliminating the co-payment would ensure access to the treatment while lowering the cost burden for the patient.

### **Eliminating Barriers to Care Coordination under Accountable Care Organizations**

The Academy believes cost sharing for patients should not be excessive in that it prohibits patients from accessing care and thus jeopardizing a necessary course of treatment. Allowing ACOs in two-sided risk models to waive beneficiary cost sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease could be a way to maintain recommended treatments. This type of proposal, as mentioned above, would also lower the cost burden for the patient.

Additionally, the Academy recommends the Committee examine policy proposals regarding the meaningful use of electronic medical records and increased interoperability as methods in which to remove barriers to care coordination under ACOs. Increased data sharing between members of the care team could lead to a more comprehensive care plan and better health outcomes for the patient.

## **Increasing Transparency at the Center for Medicare and Medicaid Innovation (CMMI)**

The Academy commends CMMI's work in developing and testing innovative payment and service delivery models as well as its willingness to seek stakeholder input on recent models. However, the Academy supports the policy proposal by the Committee to require that CMMI issue notice and comment rulemaking for the tested models that will have a significant impact on all stakeholders. Allowing for the opportunity to weigh in on the models is crucial in ensuring the developing of high quality models that lower costs and improve the quality of care.

As CMMI and private payers move from traditional fee-for-service (FFS) payment models toward alternative payment models (APMs), the Academy appreciates Congress' careful examination of this trend. The Academy believes it is important that the models themselves, as well as the regulatory framework surrounding the models, allow for and encourage flexibility and diversity with regard to the types of providers that are able to participate in these arrangements.

The Academy is working to devise and evaluate models consistent with this trend toward APMs, specifically focusing on chronic conditions and episodes of care. We are working to relate dermatological care and access to total cost and quality considerations consistent with the tenets of population-based health. A key piece of this work is finding pathways for small and solo practices to participate in APMs. Small and solo practices, for example, may need access to infrastructure and resources necessary for participation. This is a complicated process that requires balance and needs to be accomplished in a manner that does not lock certain physicians out of the marketplace.

## **Study on Medication Synchronization**

Switching therapies can lead to adverse reactions or lack of response. Adherence to a treatment plan is critical for the patient's health. Therefore, the Academy supports requiring a study to determine, in order to improve medication adherence, how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs.

Dermatologists often treat patients with chronic inflammatory, multi-system, disabling, and life-threatening conditions. To treat these conditions, dermatologists use the most cost efficient and effective therapies for patients. Biologic therapy and other specialty medications are often needed to maintain improvement and reduce co-morbidities, thus improving patient outcomes, increasing patient productivity, and constraining health care costs. Adherence to these treatments is critical to the success of patient health outcomes.

In 2013 9% of medications were either not approved by a health carrier or never filled by the patient.<sup>2</sup> Lack of continuity of care becomes concerning when necessary medications are not utilized by the patients. A streamlined process in which patients can receive all their prescriptions in one trip and obtain detailed directions for use from the pharmacist is a strategy which must be tested to see if it improves medication adherence.

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<sup>2</sup> Aitken, M., Kleinrock, M., Lyle, J., & Caskey, L. (2014). Medicines Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the U.S. in 2013. *IMS Institute for Healthcare Informatics*. Retrieved from [http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Health%20Institute/Reports/Secure/IIHI\\_US\\_Use\\_of\\_Meds\\_for\\_2013.pdf](http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Health%20Institute/Reports/Secure/IIHI_US_Use_of_Meds_for_2013.pdf).

## **Developing Quality Measures for Chronic Conditions**

The Academy supports the policy proposal to consider requiring CMS to include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Also, the Academy supports the concept of a Government Accountability Office (GAO) report on community level-measures as they relate to chronic care management.

Monitoring the quality of care provided to people with multiple chronic conditions will require measuring cross cutting issues such as diabetes, smoking, obesity as well as the quality of specialist care and the coordination of care across settings. People with multiple chronic conditions often have complex treatment needs best served by a team that includes specialty providers. Measurement science in this area is still developing and would benefit from more resources to develop measures of individual specialty care as well as measures of care coordination by a multi-specialty team.

### **Conclusion**

The Academy commends the Committee for its efforts to develop chronic care policy options and encourages you to consider our recommendations when reviewing and further updating these policies in the committee process. Should you have any questions, please contact Michelle Mathy, Assistant Director Political and Congressional Affairs, at [MMathy@aad.org](mailto:MMathy@aad.org).

Sincerely,

A handwritten signature in cursive script that reads "Mark Lebwohl, MD". The signature is written in black ink and is positioned below the word "Sincerely,".

Mark Lebwohl, MD, FAAD  
President  
American Academy of Dermatology Association