June 22, 2015

The Honorable Orin 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

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

The American Academy of Dermatology Association (Academy), which represents more than 13,500 dermatologists nationwide, appreciates the opportunity to respond to the May 22 Senate Finance Committee request for stakeholder ideas on ways to improve health outcomes for Medicare patients with chronic conditions. We commend you and the Committee for tackling this difficult but necessary issue.

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. Patients with psoriasis have an increased incidence of lymphoma, heart disease, obesity, type II diabetes, and metabolic syndrome. For skin cancer patients, the risk of getting another skin cancer increases in those who have already had skin cancer, even if the cancer has been fully treated. Optimal care for these patients requires coordination between the patient's primary care physician and dermatologist. The Academy urges you to adopt a broad definition of "chronic conditions" to ensure all patients with persistent, long-lasting and life altering conditions are able to benefit from the Committee's efforts to improve outcomes.

1) *Improvements to Medicare Advantage for patients living with multiple chronic conditions.*

The Academy believes an important factor in improving outcomes for Medicare patients living with multiple chronic conditions is access to an

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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 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.

2) *Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.*

As the Centers for Medicare and Medicaid Services (CMS) 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.

The Academy is concerned that small practices and specialty practices, including dermatology, will face barriers to participation in APMs. Small patient populations make it difficult to achieve the statistical credibility required for participation in some APMs. Additionally, small and solo practices, like most dermatology practices, often lack the infrastructure and resources required to perform certain data sharing and clinical integration functions.

Moreover, current APMs often are based on a hospital model or require close interaction with a hospital system. Some dermatologists, however, practice in rural or remote communities and their offices are not located near a hospital. Additionally, many dermatologists' have a practice that by its very nature limits interactions with hospitals. APMs need to provide the flexibility to include these small, unaffiliated practitioners as well as those who are in underserved urban areas who have infrequent interactions with hospitals.

3) *Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.*

Dermatologists and other specialists are often the providers most suitable for coordinating care of patients with chronic conditions, as well as for care

coordination for certain episodes of care. Therefore, care coordination models should include arrangements that support a specialist as the principal care coordinator of certain chronic diseases. As the Academy and its members work toward development of APMs for dermatologic conditions, we are striving to develop payment and care models that support optimum care of patients with those conditions while providing opportunities to control costs associated with that care. In the cases of certain chronic diseases, specialists most often provide the most cost and clinically effective care. Therefore, it is important that FFS care coordination changes encourage and support specialists with the skills needed to manage care of patients with chronic conditions, such as psoriasis. Such care coordination incentives are especially important to specialists in solo or small group practices.

We must ensure that patient care and medical judgement are not compromised or do not appear to be compromised by any financial incentive. Physicians must not deny their patients access to appropriate services based upon the promise of financial gain or the avoidance of financial penalties. Financial incentives must not interfere with medical judgement and patient care.

4) The effective use, coordination, and cost 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. However, 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.

Unfortunately, commercial health insurers are increasingly moving vital medications (mostly biologics with no inexpensive generic equivalents) into specialty tiers that utilize high patient cost-sharing that can range from 25% to 33% or more of a drug's costs placing them out of reach for average Americans. For example, annual maintenance therapy costs for psoriasis and psoriatic arthritis are $11,029 for traditional systemic medications and $26,708 for biologic drugs. As a result, many patients with chronic conditions go without crucial medications due to drug cost alone rather than efficacy, thus resulting in morbidity/disability and incur other health care costs that greatly exceed the proposed drug cost saving, which affects our entire health care system.

Cost-sharing should not be so large as 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.

Like specialty medications, the rising cost of generic drugs has created a barrier to patient access of needed medications. Too often patients learn of these costs when they are at the pharmacy counter. Patients are then forced to return to the physician to follow-up and receive a prescription for another, less expensive, and possibly less effective, medication. This process creates unnecessary physician visits and hinders patient adherence to medications, thus delaying treatment and possible cure of their condition. The conversation regarding drug prices should occur during the initial office visit. However, this is impossible without transparency of drug pricing within insurance plans. Improved transparency of drug costs, out of pocket maximums, and drug tiers among the many insurance companies is imperative to providing the best care for the patient. Currently this information is not readily available to the patient or the prescribing physician. Improved, transparency would allow physicians and patients to understand the cost of possible medications and allow physicians to prescribe medications that the patient will be able to fill.

Finally, treatment for patients with chronic conditions should be tailored to meet the individual patient's need. The physician should be able to make this decision based on the medical history and prior treatment of the individual patient. The physician-patient relationship is critical to determining the appropriate therapy. For example, when a physician determines that a patient is a candidate for systemic therapy (including biologics), that patient should be provided the appropriate therapy from the beginning and not be required to undergo "stepwise-therapy." The best medical therapy is often selected within the context of the patient's occupational, social, and economic environment. Stepwise therapy eliminates the ability to provide "patient-centered" care and similarly prevents "shared-decision making". These treatment decisions should be made between a physician and patient.

Payers use step therapy as a cost-containment tool to limit how much they spend on certain medications. Under this process, patients must try one or more drugs chosen by their insurer before coverage is granted for the drug prescribed by the patient's health care provider. Because these drugs are primarily chosen based on an insurer's financial considerations, these alternative drugs and therapies may not be the most effective therapy for the patient or even the most cost-effective in the end. Moreover, the process of having to progress through different therapies before being eligible for the most effective therapy, can exacerbate a disease or condition, leading to issues that may or may not require a hospitalization and very possibly and ironically increase overall costs. This is in addition to the physical, emotional and financial burden it places on the patient to have to tolerate ineffective therapies. Payers should not interfere with the practice of medicine by requiring pharmaceutical switching of medically stable patients.

5) *Ideas to effectively use or improve the use of telehealth and remote monitoring technology.*

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 access to the expertise of board-certified dermatologists when certain criteria are met. Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology. The Academy sponsors AccessDerm, a volunteer telemedicine platform, which provides trained primary care providers (PCPs) who work in participating clinics access to board-certified dermatologists to provide care to underserved populations in the United States. To date, AccessDerm has provided 1,054 total consultations, including notable diagnoses of a previously undiagnosed melanoma and Kaposi's sarcoma.

The Academy expects all telemedicine practitioners to have an understanding of the culture and other relevant characteristics of the site from which the telemedicine encounter originates. To ensure the highest standard of patient protection, our members believe a physician should be licensed by, or under the jurisdiction of, the medical board of the state where the patient is located. The Academy applauds the Federation of State Medical Boards (FSMB) for its efforts in reforming state licensure in a way that will preserve the authority of state medical boards, while also promoting patient safety, high-quality care and increased patient access.

In order to ensure patients receive high-quality care, the provision of teledermatology services should include care coordination with the patient's existing primary care physician or medical home, and existing dermatologist if one exists. Identifying the patient's existing primary care physician and dermatologist in the medical record and providing a copy to those existing members of the treatment team who do not have electronic access to it is important so that information about diagnoses, test results, and medication changes are available to the existing care team.

Telemedicine providers should have the option to choose between or combine two fundamentally different care delivery platforms: Store and Forward and 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 strongly supports patient choice. A patient who is seeking treatment for a chronic condition should be able to choose between an in-person physician or telemedicine encounter. 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.

6) *Strategies to increase chronic care coordination in rural and frontier areas.*

Utilization of telemedicine to expand access to specialty care and increase care coordination could improve care for patients in rural and frontier areas, however, the larger issue of an inadequate physician workforce remains. The Academy supports a multi-pronged approach to addressing the physician shortage including: increasing the number of Medicare supported GME positions for primary and specialty care, expanding training models to include ambulatory settings and focusing on development of more efficient health care delivery models.

7) *Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.*

Patients must have the necessary information to make informed decisions about their health care. The Academy recommends increased transparency with regard to patient health care benefits. Patients and providers should be able to quickly and easily obtain detailed information on a patient's health plan benefits so both parties are aware of coverage options, limitations and any potential out of pocket costs. Patients with chronic conditions should be able to easily see that their physicians are part of a plan, compare premiums, and see expected out of pocket costs for their physician visits and medications, in order to make an informed choice. Moreover, all pharmaceutical benefits and pricing should be readily available to the physician at the time of prescribing so the physician can integrate out of pocket patient costs with efficacy and safety into the choice of medicine. This information is increasingly important as states consider generic therapeutic and biosimilar substitution laws which can affect a physician's prescribed care plan.

8) *Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.*

Direct access to dermatologists is the easiest and most cost-effective method of providing quality dermatologic services. Studies have indicated that dermatologists, in comparison to primary care physicians, are more cost-effective and provide higher quality of care to patients with skin diseases,

including chronic conditions such as psoriasis. Improper diagnosis of skin diseases results in the following: additional costs from unnecessary diagnostic tests, office visits or treatments; possible complications from unnecessary treatments; and prolonged patient suffering. Patients experience loss of income and productivity from missed work due to misdiagnosis. There may even be increased morbidity and potential mortality from delayed diagnosis and treatment. It is critical that every patient in receiving treatment from a care coordination team have direct access to dermatologic services delivered by a dermatologist; and when clinically appropriate and required, it is also important to allow the dermatologist to serve as the principal coordinator for a patient's treatment and care.

The Academy also recognizes that there are circumstances when access to specialty care is limited or difficult to access on a regular basis. As mentioned earlier, there is potential for telemedicine to bridge this gap by allowing primary care providers to interface with dermatologists in the provision of and management of dermatologic care.

The Academy appreciates the opportunity to share our ideas and looks forward to working with you to improve health outcomes for Medicare patients with chronic conditions. If you have any questions or if we can provide any additional information, please contact Katie Jones, the Academy's Assistant Director, Political and Congressional Affairs, at kjones@aad.org or at (202) 609-6333.

Sincerely,

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