Chairman Roskam and Ranking Member Levin, on behalf of the American Academy of Dermatology Association (Academy), which represents more than 13,800 dermatologists nationwide, thank you for your leadership in convening the hearing on the “the Current Status of and Quality in the Medicare Advantage Program.” The Academy is pleased to submit the following statement for your consideration.

The Academy is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology; and supporting and enhancing patient care to reduce the burden of disease. The Academy applauds you for continuing to explore opportunities to improve the Medicare Advantage program.

As the Subcommittee convenes this hearing today, there are three issues that the Academy would like to bring to the Subcommittee’s attention.

Network Directory Accuracy

The Academy is concerned that a 2017 audit performed by the Centers for Medicare and Medicaid Services (CMS) indicates that provider directory accuracy decreased from 2016 to 2017. The analysis found that 52.2 percent of listed locations contained at least one of the following errors:

- Provider did not practice at the listed location.
- Practice phone number was listed incorrectly.
- Provider was not accepting new patients despite the directory indicating otherwise.

In 2014, the Academy brought concerns to CMS that plans were misrepresenting their provider networks by including physicians and practices that had stopped accepting that insurance, that had relocated, that had stopped accepting new patients, and, in some instances, where the physician had retired or even passed away. In response to evidence presented to CMS, in 2016, the agency began auditing network directories of Medicare Advantage plans to ensure patients were provided...
accurate directories. In the first year of audits, in 2016, CMS found that 45.1 percent of provider directory locations contained at least one inaccuracy. Unfortunately, instead of accuracy improving, in 2017, as was previously noted, 52.2 percent of the locations listed were found to have at least one inaccuracy – a 7 percent increase in one year.

The Academy is concerned that inaccurate directories create a potential hurdle for patients to access care and could misrepresent the breadth of a provider network.

The Academy recognizes that insurance companies are attempting to improve their directory accuracy through collaboration and sharing of data. However, a potential contributor to inaccurate directories is the fragmented nature of provider data collection. In a recent survey conducted by the American Medical Association\(^1\), 25 percent of physicians report receiving three or more requests for information per month from health plans. Responding to frequent and repeated requests is an administrative burden that consumes time that practices could otherwise spend on patient care. Also, despite an acknowledgement that accurate data is important, excessive requests will decrease compliance with updates. Congress and CMS could encourage industry to develop a streamlined approach to share validated non-proprietary data. Giving providers an ability to update data in one system can streamline the data validation process and provide insurers the most accurate and up-to-date information – ultimately improving the patient experience.

**Rebates**

The growth of patients’ out-of-pocket costs for prescribed drug therapies is unsustainable. Pharmaceutical manufacturers provide rebates, or Direct and Indirect Remuneration (DIR), to Pharmaceutical Benefit Managers (PBMs) and insurance companies to lower drug costs. Pharmaceutical manufacturers will introduce drugs at a higher price with the intention to negotiate the price downward with PBMs and insurers in order to gain access to the formulary. However, as recently noted by CMS, this savings is not typically passed on to the patient. In most instances, cost sharing is based on the list price, or the pre-rebate price, meaning at point-of-sale the patient pays higher coinsurance than they would if their cost sharing was based on the negotiated price or post-rebate price. Insurers will contend that rebate savings are passed on through lower premiums, but the high out-of-pocket costs makes some therapies out-of-reach for patients, leading to decreased compliance, increased complications, and higher overall health care spending.

The use of rebates has risen sharply in recent years. For example, in 2015 approximately one-third, or $100 billion, of a brand medicine’s list price was rebated back to health plans or the government

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\(^1\) AMA VerifyHCP Awareness Survey, January 2018
or kept by other stakeholders.\textsuperscript{2} This trend has likely increased due to the rising list prices and concentration of supply chain stakeholders.

Recently, some insurers, such as UnitedHealthcare and Aetna, announced they are devising strategies to pass rebates on to patients in their fully insured markets. The Academy encourages insurers to share these savings, and pass rebates on to the patients in the Medicare Advantage market.

**Prior Authorizations**

Physicians are facing significant burdens meeting Medicare Part C and D plans’ prior authorization requirements for medically necessary drugs. The Academy recommends requiring CMS to alleviate this burden by requiring Medicare Advantage and Medicare Part D participating plans to shorten the turnaround time for prior authorizations and to extend the length of the prior authorization appeal period. The Academy also recommends that CMS encourage plans to provide detailed explanations for prior authorization denials, including the clinical rationale, the covered alternative treatment and details on the provider’s appeal rights. Furthermore, the AADA recommends that CMS standardize the prior authorization form across all Medicare Advantage and Medicare Part D plans as well as shorten the time the payer has to make and inform the provider of the prior authorization decision and of the appeal period.

Physicians also face difficulties in accessing the prior authorization requirements for specific plans. The Academy believes plans must make the following information current and publically available in a searchable electronic format: the prior authorization requirements, documentation and information necessary for completing a prior authorization, and a direct telephone number for physicians and their staff to call regarding prior authorizations (not the main prior authorization line). Additionally, the Academy recommends that all exceptions decisions be made by a provider who is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider.

Another important step in streamlining prior authorizations is for CMS to encourage plans to allow for electronic prior authorizations (ePA). The Academy supports the “Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018,” (H.R. 4841) which would require CMS to provide for the development of an ePA standard for Medicare Advantage and Part D plans, and encourages Congress to pass the bill this year.

\textsuperscript{2} Vandervelde A, Blalock E; Berkeley Research Group. The pharmaceutical supply chain; gross drug expenditures realized by stakeholders. 2017.
Again, the Academy appreciates the Subcommittee holding this hearing today, and the Academy appreciates the Subcommittee’s efforts to improve the Medicare Advantage program. Please feel free to contact Michelle Mathy, the Academy’s Assistant Director, Political and Congressional Affairs at mmathy@aad.org or (202) 609-6333 if you have any questions or if we can provide additional information.