NEW HAMPSHIRE SOCIETY OF PATHOLOGISTS

One Medical Center Drive• Lebanon, NH 03756

September 30, 2015

Mr. Tyler Brannen
Health Policy Analyst
New Hampshire Insurance Department
21 South Fruit St, Suite 14,
Concord, NH 03301

Dear Mr. Brannen:

On behalf of the New Hampshire Society of Pathologists and with the support of the College of American Pathologists, I am writing to offer our input on the draft recommendations created by Compass Health Analytics. We greatly appreciate the open, thoughtful and deliberative process that allows stakeholders to participate and offer expertise in the formulation of New Hampshire's insurance network adequacy rules. As pathologist physicians, our primary concern is the welfare of our patients. Accordingly, the comments we are submitting are designed to strengthen the proposed rules in order to ensure that New Hampshire patients, whether healthy or critically ill, can receive all medically necessary pathology services within the insurance networks in which they are enrolled. Any network plan that cannot provide minimum pathology services, as we delineate, should be disallowed under the proposed rules as patients will not be receiving medically necessary pathology services under the in-network coverage plan.

The current model groups services for purposes of assessing network adequacy using the following criteria:

Core services must be available in the same or an adjacent community

Common services must be available in the same or an adjacent community

Specialized services must be available **in the state**

Highly specialized services must be available in New England

The current working draft identifies only an array clinical laboratory services as "core services" (see attached). All of the services listed are basic clinical laboratory services. There are no professional pathologist services, and no CPT services listed for the medical specialty of pathology from the physician fee schedule under Medicare. In addition, core pathology services such as the Pap test appear to be omitted as well. The exclusive focus on clinical laboratory services as "core services" and the

extraordinary absence of physician pathologist services from any consideration under network adequacy strongly suggests this draft list did not fully consider medical and physician input and current baseline standards of pathology services that patients require.

For patients undergoing surgical procedures, or presenting with acute illness, or cancer, this list is insufficient. For example, network adequacy for anatomic pathology services which must be done promptly in a laboratory that is proximate, if not adjacent to the surgical site of service is not considered in this draft. This consideration is a basic medical standard of care. Another area of omission that is now a standard of care is molecular pathology (including cancer biomarker assessment) that does not appear to be included as "core services." Consequently, under this network adequacy model, New Hampshire patients with cancer will not have necessary network adequacy to support initial in-network screening, diagnosis, or in-network treatment monitoring.

To that end, we urge the development and inclusion of network adequacy criteria based upon the following considerations:

Does the Plan's network of contracting laboratories and pathologists provide access to intra-procedural pathologist consultations when immediate assessment of the specimen is necessary?

Medical justification: Specimens obtained using interventional imaging techniques or outpatient surgery in surgery centers may require immediate assessment so that the radiologist or surgeon can manage care during the procedure. For example, a surgeon performing a breast lumpectomy with sentinel lymph node biopsy and possible axillary dissection must have the sentinel lymph node examined while the patient is anesthetized in order to determine whether additional axillary dissection is indicated.

Does the Plan provide access to subspecialist laboratory and pathology services (e.g. neuropathology hematopathology, molecular pathology) when required by professional standards of care as determined by the primary pathologist for the evaluation, diagnosis and treatment of enrollees?

Medical justification: Generalist pathologists may not have sufficient experience with some uncommon disorders to optimally evaluate them. The recent rapid expansion of knowledge about the molecular basis and treatment of uncommon neoplastic and non neoplastic diseases, may also be beyond the scope of practice of non- subspecialist treating physicians and pathologists. **EXAMPLES:** The evaluation of developmental brain disorders necessitating surgical resection for intractable epilepsy (i.e. cortical dysplasia or Sturge-Weber syndrome) or of muscle biopsies for neuromuscular disorders (i.e. Duchenne muscular dystrophy or myotonic dystrophy). Stepwise molecular evaluation for EGFR and KRAS mutations followed by molecular evaluation for ROS1 and ALK mutations for primary or metastatic lung cancer where the mutations are mutually exclusive of one another and therefore testing is done from the most common to least common, but if any of these mutations are present the findings result in targeted therapy.

Does the Plan allow for laboratory and pathology services outside the Plan's contracted network, if the service is either not available in network or if testing was begun out of network and standards of practice require serial testing by the same laboratory to ensure comparability of results and provide continuity of care?

Medical justification: There are no laboratories that provide all of thousands of tests available and necessary for the evaluation of health and disease status, and the Plan must allow access to tests not available from network providers. Test results can vary when done using different methods or method instrument combinations. When a series of tests is begun using one method it should be continued with the same method, or if the testing is shifted to a new method there should be a period when both methods are used to allow a transition that does not harm the patient.

Does the Plan have policies or guidelines that allow a pathologist to obtain an outside second opinion (consultation) when necessary to meet professional standards of care as determined by the primary pathologist?

Medical justification: A primary pathologist may require a second opinion from another, usually subspecialist, pathologist for a variety of reasons including the presence of an unusual condition, atypical manifestation of a disease, or lack of local access to specialized testing.

Does the Plan allow specialty pathology and laboratory services outside the Plan's contracted network if the service is not available in-network and is medically necessary for the enrollee?

Medical justitification: When the Plan does not contract with sufficient numbers or types of subspecialists to meet enrollee needs, the primary pathologist must have access to out of Plan pathology subspecialists.

In sum, without consideration of these aforementioned basic pathology services the Insurance Department will not be developing insurance network adequacy standards that comports with basic minimum standards of pathology services for patients. Accordingly, we urge consideration of this information and incorporation of physician pathology services, as delineated herein, into these standards.

Sincerely,

Claire Fabian, MD, FCAP
President, New Hampshire Society of Pathologists