January 26, 2022

Linda Simmons
Vice President, National Lab Program
UnitedHealthcare
9900 Bren Rd E, Minnetonka, MN 55343

Via email to linda_m_stewart@uhc.com

RE: Designated Diagnostic Provider

Dear Ms. Simmons:

The undersigned physician and hospital organizations are writing to express consistent and collective concerns about UnitedHealthcare's (UHC) Designated Diagnostic Provider (DDP) program. While we appreciate the outreach UHC has conducted and the open channels it has maintained over the past year in explaining the details of how DDP is designed to function—along with the subsequent clarifications and overhaul to this program—we nevertheless urge UHC to forego the current approach and instead seek closer stakeholder collaboration with and input from the undersigned professional medical organizations. We believe that patients and their physicians, who depend on outpatient hospital and independent pathology laboratory services, deserve timely access to diagnostic laboratory services as directed and deemed appropriate by the ordering physician.

We understand that cost and affordability are important factors in offering a value proposition in plan benefit design to your health insurance clients who purchase coverage for their employees. However, when these beneficiaries become subject to narrow network constraints and their physicians, in turn, are forced to redirect referrals from their preferred pathology laboratories—where there has been a well-established and trusted care coordinating relationship—to new laboratories, we maintain that these barriers and burdens hinder care for patients and lead to counterproductive results regardless of a health plan's intent to add transparency and promote cost management.

Though we share UHC's goal of creating value and transparency in outpatient pathology laboratory services, we believe that DDP will cause unintended consequences for ordering physicians and their patients when diagnostic laboratory services are required to inform safe and timely clinical decision making. By rolling out DDP as a re-designed tiered quality and efficiency benefit plan, UHC will confuse patients with "in-network" and "designated provider" terminology and constrain access by requiring treating physicians to forego reliable and trusted in-network independent and hospital outpatient laboratories, forcing them to refer laboratory orders instead to unfamiliar DDP alternatives. Indeed, the novel coronavirus, COVID-19, has

taught us that lack of access to testing locations results in significant disparities in outcomes.[1] Particularly for those who lack reliable methods of transportation, patients tend to select laboratories that are geographically convenient to their work or home. Failure to include these laboratories in the DDP program will exacerbate access and outcome inequities.

Undermining the Patient-Physician Relationships

The patient-physician relationship is the cornerstone of health care. This fundamental and mutually established clinical relationship is based on meeting the medical needs of a patient seeking relief from suffering, and is driven by trust, professional responsibility, and ethical duty of care.[2] To force ordering physicians to refer diagnostic services to laboratories with which they are neither familiar nor have an established consultative relationship, will constrain the physicians' professional judgment in seeking a trusted pathologist of their choice with whom to reliably consult on pathology laboratory results as part of coordinating care and making clinical judgements for the benefit of patients. Rather than offering constructive direction to patients and their physicians, we foresee scenarios in which patients will second-guess and challenge their treating physicians for referrals of laboratory orders. By pitting patient's short-term financial interests against their treating physician's judgement and expertise, this program will strain an otherwise healthy and trusted patient-physician relationship and impair access for patients to critical diagnostic services.

Confusing Patients and their Physicians

We acknowledge that UHC's revisions to the original DDP design are a step forward as it removes the earlier arbitrary network inclusion or exclusion divide. Additionally, promoting transparency for patients to make informed decisions about their care in consultation with their treating physicians is laudable and welcomed. Still, we maintain that the current update does not go far enough to mitigate potential confusion that may arise for patients and their treating and referring physicians. The current DDP tiered benefit design, where "in-network" laboratories will still be at risk of being excluded from DDP altogether, will lead to patient confusion and distress in addition to the strained patient-physician relationship outlined above.

First, UHC's novel definition and application of "in-network" is a radical departure from what has been a longstanding and well understood benefit term, especially for patients accustomed to the original meaning. We expect that patients will be confused by this usage and will become frustrated upon learning that their "in-network" access for diagnostic laboratory services has been curtailed. Further, patients will likely be confused to find out they are liable for higher out-of-pocket payments when the diagnostic service was provided by an "in-network" non-DDP laboratory. Again, short of assurances that DDP laboratories will be easily accessible to all patients, this paradigm sets the stage for inequitable care.

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[1] https://pubmed.ncbi.nlm.nih.gov/33668958/ and https://www.nia.nih.gov/news/why-covid-19-testing-key-getting-back-normal

[2] AMA Code of Medical Ethics: 1.1.1 Patient-Physician Relationships.

Finally, by advancing the DDP program, UHC will limit the number of in-network laboratories that will be eligible for top-tier reimbursement for pathology services. Such a health benefit plan design will lead to access constraints and disengagement by patients, create reduced laboratory referral options for ordering physicians, and result in avoidable and unnecessary administrative burdens, all of which, when combined, introduce a counterproductive and confusing environment for patients seeking timely, appropriate, and quality care.

Disrupting Clinicopathological Correlation

The DDP design does not distinguish among the various types of pathology laboratory services available to ordering physicians in treating their patients. Much like the patient-physician relationship, the professional relationship that exists between physicians and their trusted pathologists is established over time and based on regular consultation that is founded on collaboration, integrity, and reliability. For example, physicians rely on both clinical and anatomic pathology laboratory services, based on professional and thoughtful discussions between the ordering physician and the rendering pathologists about microscopic review and description, including differential diagnoses when appropriate. The importance and value of proper clinicopathological correlation leads treating physicians to rely on pathologists with special expertise in anatomic, clinical, and molecular pathology. These relationships and the access to high levels of expertise help physicians provide the highest quality and highest value care possible. For example, clinicopathological correlation in surgical pathology is essential for generating the most accurate histopathologic diagnosis. Thus, the immediate availability of clinical data from the patient chart, including clinical photographs, allows for instant correlation of the clinical presentation with the histology. Careful communication assists in deciding when follow up is appropriate or what, if any, additional treatment is needed. Pathologists often alert treating physicians to important considerations in differential diagnosis. Over time, the ability to transfer information between clinician and pathologist is refined, and clinicopathological correlation improves along with trust and mutual understanding.

Disproportionate Adverse Impact on Small Independent Laboratories

While we welcome UHC's efforts to revise DDP from its original "in-or-out" design to a tiered-based model, we remain concerned that the January 2022 rollout will harm smaller independent pathology groups, putting them at a disadvantage by being unable to qualify for DDP designation. This unintended consequence will create a ripple effect by causing disruption in longstanding professional referral relationships between treating physicians and their trusted and preferred pathologists. Such disruption will negatively impact access to timely and accurate pathological interpretations, thereby affecting the quality in diagnosis and evaluation.

Recommendations for Ensuring Patient Access to Timely and Accurate Laboratory Test Results

As hospitals, medical practices, laboratories, and other health care settings face ongoing hardships and disruptions brought on by the COVID-19 pandemic, we urge UHC to withdraw the DDP program altogether in the interest of their beneficiaries—and our patients. Instead, we

ask UHC to invite all medical and hospital professional organizations to the table for a robust and constructive dialogue on how all parties can contribute to reaching a consensus that equitably advances value to covered beneficiaries and health plan purchasers. Understanding the wide array of diagnostic laboratory services as well as appreciating the complexities associated with pathology services is the first step needed in designing value for patients, their ordering physicians, and their corresponding pathologists. If you have any questions, please contact Lou Terranova, Assistant Director, Practice Advocacy at lterranova@aad.org or by calling (202) 340-2875.

Sincerely,

American Academy of Dermatology/Association
American College of Obstetricians and Gynecologists (ACOG)
American College of Rheumatology
American Medical Association
American Society of Dermatopathology
College of American Pathologists
Medical Group Management Association

cc: Rachelle Kostial, UHC