



AMERICAN OSTEOPATHIC ASSOCIATION

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July 27, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (the "Proposed Rule")

Dear Acting Administrator Slavitt:

On behalf of the American Osteopathic Association (AOA) and 32 state osteopathic medical associations, thank you for the opportunity to comment on CMS' proposal to modernize the requirements governing the provision of health care services to Medicaid patients through Medicaid Managed Care (MMC) plans. The AOA and its state osteopathic medical associations represent 110,000 osteopathic physicians and osteopathic medical students nationwide.

Osteopathic physicians (DOs) have a particularly strong and ongoing commitment to the provision of high quality primary care and other medical services to the Medicaid patient population. While DOs comprise an estimated 8 percent of all U.S. physicians, more than 60 percent of DOs in active practice with self-identified specialties are primary care physicians. They also comprise 40 percent of all physicians who practice in medically underserved areas, where a disproportionate number of Medicaid eligible patients reside. For these reasons, DOs serve a critical role as first-line providers of care to Medicaid patients.

We commend CMS for its effort to make the care provided to Medicaid patients through MMC plans more consistent with that provided to patients enrolled in Qualified Health Plans (QHPs) obtained through the ACA marketplaces. Our more specific recommendations and observations are set forth below.

Network Adequacy

The AOA strongly supports increased access to health care services for special populations, including those in rural and medically underserved areas.

The quality and accessibility of care provided to the Medicaid patient population by MMC plans depends to a very large extent on the quality and stability of the participating physicians. State and federal oversight of this aspect of MMC operations historically has been somewhat limited. In light

of DOs' experience in various states as described above, we have the following observations and recommendations with regard to the Network Adequacy provisions of the proposed rule:

- At least initially, we urge CMS to take a central role in the establishment and application of network adequacy standards by MMC plans. This area has been virtually unregulated since the ascension of Medicaid managed care, and for this reason we believe that significant federal oversight is necessary and appropriate.
 - We firmly believe that the establishment and ongoing maintenance of stable physician-patient relationships is critical and that attention should be directed not only to the accessibility of provider networks, but to their stability. For this reason, we urge CMS to include a requirement that MMC plans provide periodic reports of provider turnover to the state and to submit appropriate remedial plans in the event of excessive provider turnover.
 - State-based physician associations, including, but not limited to, those representing DOs, are in the best position to identify potential deficiencies in network adequacy. We urge CMS to require state Medicaid agencies to solicit the views of state medical associations representing physicians and others who provide primary care, behavioral care, and pediatric care regarding network adequacy, and to require MMC plans to respond in writing to any comments made by these groups noting deficiencies in access.
- We support the use of time/distance requirements to help ensure network adequacy, but caution that Medicaid patients' access to medically necessary health care services is often impacted by lack of transportation altogether. To the extent that public transportation is not available, time and distance requirements may prove an insufficient measure of true accessibility to health care services. We agree that states should therefore consider a multitude of other factors, including the actual utilization of health care services by Medicaid patients. In considering these other factors as CMS proposes, we believe more details are necessary regarding how determinations will be made and what measures would be in place to ensure the information is accurate, particularly as it relates to the availability of health care professionals.
 - We would appreciate additional clarification on the distance requirements. Do the distance requirements include the shortest distance between two points, or actual driving distance from a beneficiary's residence? We want to note that simply using the shortest distance between two points can create obstacles to accessing health care services, as it did in the Veterans Choice Program. Using actual driving distance from a beneficiary's home is a more accurate measure in determining his or her accessibility to needed health care services.
 - To the extent that Medicaid utilization of services from particular regions or for particular services is substantially lower than might be anticipated, we believe that states should require MMC plans to conduct root cause analyses of barriers to access, and to provide an appropriate remedial plan. MMCs should be encouraged to coordinate the provision of health services with the provision of other social services, including transportation assistance that may be available through various state or federal "safety net" programs.
 - We also encourage the consideration of telemedicine coverage to provide access to needed health care services, as appropriate.

- AOA members in a number of states have raised concerns about the severe lack of access to behavioral health care for Medicaid patients, under both MMC and Medicaid fee-for-service (FFS) systems. For this reason, we support the establishment of separate time and distance requirements for behavioral health providers, as set forth in the proposed rule. We also urge that network adequacy for behavioral health services be specifically reviewed and signed off on by the state agency or subunit that has responsibility for the provision of state mental health services.
- Finally, we note that MMC plans should be monitored to ensure that they do not categorically exclude physicians who self-report under CMS Specialty Code 12 (Osteopathic Manipulative Medicine) from participation, and that they provide adequate coverage for Osteopathic Manipulative Treatment (OMT). For example, we have received numerous reports from AOA members who have been denied Medicaid payment for providing Evaluation/Management and OMT services on the same day, despite their use of modifier-25, which is acceptable according to national coding standards. Often physicians are unable to appeal, given the amount of time and resources that is required, and Medicaid patients are losing access to OMT services as a result.

Establishing Adequate Payment for Services Provided to Medicaid Patients

The AOA supports efforts for each state to uphold its obligation to pay physicians and hospitals at a fair and equitable rate for providing quality care to the state's Medicaid recipients. The AOA believes that the inadequacy of Medicaid payment rates to providers, especially for much-needed primary care and care coordination services, has been one of the most significant obstacles to high quality, accessible care for the Medicaid patient population under both MMC and Medicaid FFS programs. For example, in Maine physicians receive only 30 percent of the Medicare fee schedule for Medicaid patients, resulting in very few points of access to care for the neediest patients.

The AOA strongly supports the establishment of Medicaid rates in FFS and MMC for primary care services provided by Primary Care Physicians (PCPs) at amounts that equal or exceed the amounts paid for the same services under the Medicare program. Preliminary data shows that this will increase access to care for Medicaid beneficiaries. A study by the University of Pennsylvania's Leonard Davis Institute of Economics found that appointment availability increased by 7.7 percent following the Medicare/Medicaid payment parity provision for primary care services provided under the Affordable Care Act.¹ States should require that MMC Plans provide at least this level of payment for primary care services provided to Medicaid patients.

In setting rate development standards, CMS proposes to define risk adjustment as "a methodology to account for health status of enrollees" under the managed care contract. To ensure a patient-centered approach, and payment that adequately compensates physicians for the services provided, the AOA urges CMS to also include socioeconomic factors in its risk adjustment calculations. Medicaid patients face significant challenges in their efforts to maintain their health and well-being that other patient populations generally do not face.

Osteopathic physicians are uniquely positioned to understand how indicators such as low-quality housing, limited access to healthy food, poor education, and limited job opportunities directly impact an individual's health and his/her ability to prevent and fight disease. As a result, physicians

¹ http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_137.pdf

must dedicate more time and resources to provide the proper care for these patients, yet Medicaid's current payment rates do not adequately cover the costs of providing the much needed services for its patient population. This will further dis-incentivize physicians from serving individuals in the program.

We applaud CMS' proposal to establish a minimum MLR for MMC plans. CMS is proposing a minimum MLR of 85 percent for MMC plans, and its analysis found that the average MLR of Medicaid plans was already between 85.5 and 87.9 percent. Although one-fourth of plans had MLRs below 83.6 percent, we do not believe that establishing a minimum 85 percent MLR alone will address the inadequacy of provider rates.

We note that the Medicaid patient population may differ in key respects from the general patient population -- this can be especially true for dual eligible patient populations and those with multiple chronic conditions (including children with multiple chronic conditions). We therefore urge CMS to include in the medical expense portion of its MLR calculation certain physician administrative activities that directly provide physicians with data they use to improve the quality of their patient care. While not direct patient care, activities that enable population health management, care coordination, and patient engagement should all be included in it rather than in the administrative expense portion of the calculation, though we caution against it being to the detriment of the physician's overall payment.

Finally, the AOA supports limits on utilization management and pre-approval requirements as described in the proposed rule. If aggressively applied, these practices can result in the inappropriate curtailment of necessary services, particularly for those with on-going and chronic conditions. By establishing limits on their usage, CMS can maximize opportunities for such individuals to have access to the benefits of community living and the opportunity to receive both clinical and non-clinical services in the most integrated setting.

Health Delivery Reform through MMC Plans

AOA strongly supports new delivery models that enhance and promote the role of primary care physicians as the foundation for the health care system and emphasize the provision of coordinated care across the health care spectrum. The AOA supports the proposed rule's objective to engage states in meaningful delivery reform through requirements imposed on MMC plans.

For example, CMS proposes:

- To add a new incentive arrangement standard requiring these arrangements be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes;
- To authorize states to use withhold arrangements to drive health plan performance toward specified goals or outcomes by retaining an amount from the base capitation rate payable to the plan unless satisfactory performance is achieved; and
- To allow states to specify in the contract that managed care plans adopt value-based purchasing models for provider payment, or to require plan participation in delivery system reform or performance improvement initiatives (including multi-payer or community-wide initiatives).

The AOA supports health delivery reform initiatives intended to improve quality and efficiency. However, we caution that MMC plans should not be able to place providers at risk for plan performance with respect to quality and efficiency objectives that rest solely within the control of plan administrators. Similarly, MMC plans should not be authorized to simply pass on to providers the risk resulting from state withhold and incentive arrangements. Any withhold arrangements imposed by MMC plans at the provider level should be based on quality and value criteria that fall clearly within provider control. In addition, they should be based on clearly defined and transparent quality and efficiency metrics that are disseminated broadly to the affected participating providers and that use a common set of performance measures across all payers and providers, so that CMS can evaluate the degree to which multi-payer efforts achieve goals of collaboration. In addition, any quality incentive arrangements should be streamlined and structured to minimize the administrative burden on providers.

Primary Care/Care Coordination

The AOA believes that it is critical to treat the “whole person”, and primary care is the cornerstone to effective patient-centered care and coordination. A number of states have adopted the Patient-Centered Medical Home (PCMH) and we believe that the physician-led PCMH model can address many of CMS’ concerns regarding Medicaid patient access to high quality and coordinated primary and specialty care. In this regard, AOA strongly supports expanding PCMH standards to ensure that care coordination activities involve coordination between care settings, as well as community and social support services.

We also recognize the value of the services currently being delivered by enhanced Primary Care Case Managers (enhanced PCCMs), and further believe that expanding this approach to primary care case management by establishing guidelines for PCCM entities is appropriate. We also agree with CMS that these newly recognized entities should continue to be distinct from the traditional, more limited in scope, PCCMs. In delineating these guidelines, we encourage CMS to continue to recognize the important role physicians play in case management, as evidenced by the physician-led care teams that have shown success in the PCMH.

While the proposed rule notes that other health care delivery systems like the PCMH would not be subject to the standards of part 438, further rulemaking could provide an opportunity to better align and clarify the respective roles of the PCMH and the enhanced PCCM in a new Medicaid system. In doing so, we caution that the PCMH should not be in any way disadvantaged by the advancement of the PCCM.

Beneficiaries

The AOA supports revisions to the beneficiary appeals processes set forth in the proposed rule, most especially the provisions that would preclude MMC Plans from discontinuing services pending appeal. We understand, as CMS points out, that the right to continuation of benefits puts the beneficiary at potential financial risk for payment of services provided, if the final decision is adverse to the beneficiary. It should also be considered that the physician providing the service is also potentially placed at financial risk in these cases.

The AOA also supports the proposed 14-day choice period for beneficiaries to affirmatively choose a managed care plan or opt for FFS coverage, and the provisions in the proposed rule that require states to “preserve provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid” when beneficiaries are assigned or reassigned to MMC Plans.

We support increasing beneficiary access to explanatory plan material, including provider directories, as described in the proposed rule. We also strongly support the proposed rule's provisions requiring the publication and dissemination of up-to-date provider directories as the importance of patients having access to accurate directories cannot be overstated. Incorrect or out-of-date information diminishes the transparency of the program, and patients are left confused over whether or not a physician is participating in a given plan. In addition:

- It is critical for directories to be available in both electronic and in paper format, and that monthly updates are made available at least electronically to ensure accuracy and to indicate whether or not a physician or provider is accepting new patients. Periodic updates can improve access to care and would maintain the accuracy of the directories by hastening the removal of out-of-date or incorrect information.
- We call on CMS to ensure that validating this information throughout the year in order to update the directories does not create another administrative burden on the physician's practice. We also caution that many Medicaid patients may not have regular access to the internet or other computer-based technologies, and encourage dissemination of paper directories through alternative communications networks, including religious institutions, schools, and community centers.
- The AOA recommends that when directories list physicians by specialty, Osteopathic Manipulative Medicine physicians should be listed separately or cross-referenced if they are only included under the specialty of Family Medicine.
- The agency should move forward with the use of application programming interfaces (API). We agree that provider directories with standardized APIs could be leveraged to create applications that are more beneficial for consumers than non-standardized web sites. We also agree that medication formularies should be made available electronically and on paper and updated as needed to help beneficiaries understand how medications are covered by managed care plans.

The AOA supports the promotion of transparency and efforts to address disparities such as accessibility for enrollees with physical and mental disabilities, and believe that network providers should demonstrate the ability to communicate in a cultural competent manner. We urge CMS to provide more details regarding how cultural competency and reasonable accommodations will be determined.

We recognize the importance of MMC plans and/or the States engaging enrollees and using surveys to assess their experiences. However, we have concerns about the subjectivity of patient experience measures, and the inability to accurately and solely capture aspects of care or experience over which an individual physician has direct control. Physicians should not face payment penalties or sanctions based on elements of care outside of the physician practice's control.

Finally, the AOA supports Managed Long Term Services and Support (MLTSS) Guidance that promotes stakeholder engagement, home and community-based services, person-centered processes, beneficiary support, and education.

Health Information Technology

The AOA continues to support the use of health information technology (HIT), and agree that the electronic exchange of health information is an important tool for achieving care coordination objectives and in providing quality health care services. We appreciate HHS' commitment to

accelerating health information exchange through the use of HIT; however, many challenges still need to be addressed. CMS should focus its efforts on improving interoperability rather than simply moving more data. For example, CMS needs to ensure that the way electronic health records communicate with state agencies is standardized. The current lack of uniformity at the state public health agency level, for example, can have a negative impact on the cost of ownership of EHR technology for physician practices due to the need for multiple interfaces.

We agree that Medicaid programs specifically need timely, robust and accurate data and that these data need to be standardized. We concur that collecting data from providers should be in standardized formats, to the extent feasible and appropriate, to help alleviate administrative burdens on the physician practice and facilitate interoperability. Such data could be a value to physician practices in the collaborative efforts to improve the overall quality of care. We also encourage that the Health Information System (HIS) used by each MCO, PIHP, and PAHP be standardized as part of the effort to achieve greater interoperability and data-sharing, as outlined by the Office of the National Coordinator for Health IT.

The AOA and undersigned state osteopathic medical associations appreciate the opportunity to comment on the proposed rule, and look forward to working with CMS in ensuring increased access to high quality medical services to the Medicaid patient population.

Sincerely,

American Osteopathic Association
Alaska Osteopathic Medical Association
Arizona Osteopathic Medical Association
Arkansas Osteopathic Medical Association
Osteopathic Physicians and Surgeons of California
Colorado Society of Osteopathic Medicine
Connecticut Osteopathic Medical Society
Hawaii Association of Osteopathic Physicians and Surgeons
Illinois Osteopathic Medical Society
Iowa Osteopathic Medical Association
Kansas Association of Osteopathic Medicine
Louisiana Osteopathic Medical Association
Maine Osteopathic Association
Massachusetts Osteopathic Society
Michigan Osteopathic Association
Minnesota Osteopathic Medical Society
Mississippi Osteopathic Medical Association
Missouri Association of Osteopathic Physicians & Surgeons
Nevada Osteopathic Medical Association
New Hampshire Osteopathic Association
New Jersey Association of Osteopathic Physicians & Surgeons
New York State Osteopathic Medical Society
Ohio Osteopathic Association
Oklahoma Osteopathic Association
Osteopathic Physicians & Surgeons of Oregon
Pennsylvania Osteopathic Medical Association

Rhode Island Society of Osteopathic Physicians & Surgeons
South Carolina Osteopathic Medical Society
South Dakota Osteopathic Association
Tennessee Osteopathic Medical Association
Texas Osteopathic Medical Association
Vermont State Association of Osteopathic Physicians & Surgeons
Washington Osteopathic Medical Association