November 13, 2019

The Honorable Donald J. Trump
President of the United States of America
1600 Pennsylvania Ave., NW
Washington, DC 20500

Re: October 3, 2019 Executive Order on *Protecting and Improving Medicare for Our Nation's Seniors*

Dear President Trump,

On behalf of the more than 145,000 osteopathic physicians and osteopathic medical students represented by the American Osteopathic Association and undersigned specialty and state osteopathic associations, and the patients they serve, we write to express our comments and recommendations regarding the October 3, 2019 Executive Order on *Protecting and Improving Medicare for Our Nation's Seniors.*

Osteopathic medicine is one the fastest growing health care professions in the country, with one in four medical students in the United States attending a college of osteopathic medicine. Our organizations are committed to working with your administration, the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and Congress, and share your commitment to ensuring that our nation's seniors and other vulnerable Americans have access to the highest-quality, affordable care, from the health care professionals of their choice.

Doctors of osteopathic medicine (DOs) play a critical role in increasing access to care in our country. As you may know, the osteopathic medical profession is one of the most dynamic segments in health care. Since 2010, the number of DOs has increased by 54 percent. Today, more than 65 percent of all DOs are under the age of 45, and if current trends continue, DOs are projected to represent more than 20 percent of the U.S. physician workforce by 2030. Additionally, more than 40 percent of active DOs practice in non-primary care specialties. Because DOs take a "whole person" approach to patient care by focusing on prevention and care coordination as keys to maintaining health, we recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and care when and where they need it. With that in mind, we respectfully offer the following comments and recommendations on the Executive Order, and we welcome the opportunity to engage with your administration as efforts to improve care for our nation's seniors move forward.

Sec. 2. Policy.
We are committed to quality improvement in health care and support the Administration's efforts to develop a Health Quality Roadmap to align clinical quality measures across CMS' value-based programs. However, we would caution that substantial program changes from year-to-year increase administrative burden, complexity, cost of the program, and run counter to CMS' Patients Over Paperwork initiative. We recognizes the potential promise of Alternative Payment Models (APMs) and encourages the Administration to move forward with APMs approved by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that have received robust input from relevant specialties.

Sec. 3. Providing More Plan Choices to Seniors.
We appreciate the Administration's goal of providing Medicare beneficiaries with more diverse and affordable plan choices and encouraging innovative Medicare Advantage plan designs. We support increasing access to, and payment for, telehealth services. For America's seniors, and other vulnerable

populations, whether because they reside in a Health Professional Shortage Area (HPSA), are of limited mobility, or lack reliable transportation, telemedicine provides a means of accessing care for people who might otherwise delay or go without treatment.

To that end, we support enactment of the Interstate Medical Licensure Compact (Compact), which provides a voluntary, expedited pathway to physician licensure in multiple states. The Compact increases access to healthcare for patients in underserved or rural areas by allowing them to more easily connect with physicians through the use of telemedicine and other communications-based technologies.

We would, however, urge caution in the development of potential modifications to Medicare Fee-For-Service (FFS) payments to encourage price competition. While it is well-documented that Medicare pays for medical services at rates that are lower than those of commercial insurers, policy proposals to bring Medicare payment rates closer to those of commercial insurers should not increase costs incurred by Medicare beneficiaries or negatively impact the Medicare Trust Fund.

Sec. 4. Improving Access Through Network Adequacy.

We encourage the Administration to strengthen health insurance network adequacy in all markets. In recent years, more patients have found themselves in plans with narrow provider networks as plans reduce their network options as a way to control cost. When insurers contract with fewer providers, it limits choice and access for consumers. Additionally, narrow insurance networks reduce patients' ability to access affordable care. The growing problem of surprise medical billing is in part a byproduct of narrow insurance networks, resulting in many physicians being out of network, effectively requiring physicians to pursue payment directly from their patients.

Strong oversight and enforcement of network adequacy requirements is needed from federal and state governments. A study published in the Journal of the American Medical Association (JAMA) in 2015 found that nearly 15 percent of health plans were specialist deficient, and beneficiaries of specialist deficient plans had high out-of-network costs. More than a quarter of these plans did not cover out-of-network services and the remainder required 50 percent cost sharing. This is especially concerning in rural areas where access to both providers and coverage options is limited.

Strengthening network adequacy standards in all markets will protect patients and lower out-of-pocket costs. Robust network adequacy standards include, but are not limited to, an adequate ratio of in-network emergency physicians, other hospital-based physicians, and on-call specialists and subspecialists to patients, as well as limits on geographic and driving distance standards and maximum wait times. Further, although telehealth can help improve patient access to care, it may not be appropriate in all instances and should not be used to fulfill network adequacy requirements.

One important and proven way to improve network adequacy and increase the presence of needed specialists in HPSAs is the development and expansion of programs that promote and support the presence of health care specialists in the areas that they are needed most. Examples of this include the Teaching Health Center Graduate Medical Education program, which supports training for primary care physicians in rural and underserved communities, and the Substance Use Disorder Workforce Loan Repayment Program, which provides loan repayment for health professionals providing mental health and substance use treatment services in HPSAs and counties hardest hit by the opioid crisis. Additional programs that support training and clinical practice in rural and underserved areas would increase the physician workforce in areas with limited network participation.

Sec. 5. Enabling Providers to Spend More Time With Patients.

We support efforts to reduce administrative burden, including via CMS' Patients Over Paperwork initiative. However, it is imperative that any efforts to reduce regulatory burden do not come at the expense of patient safety.

We support a "team" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. Physician education, for DOs and MDs alike, is comprised of four years of medical school, which includes two years of didactic study totaling upwards of 750 lecture/practice learning hours just within the first two years, plus two more years of clinical rotations done in community hospitals, major medical centers, and doctors' offices. Postgraduate medical education (i.e. residency) includes 12,000 to 16,000 hours of supervised training over the course of 3-7 years, during which time physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions before they are allowed to independently deliver care to patients. In addition to the comprehensive, three-part examination series that all physicians complete in order to obtain an unlimited medical license, over the course of their careers, the vast majority of physicians also complete extensive continuing medical education and rigorous board certification examinations which reflect the highest degree of achievement in their chosen medical specialty.

Other non-physician clinicians, while important members of the health care team, receive significantly less training than physicians, and significant variations in requirements exist among states, even within a single profession. Some non-physician clinicians are only required to complete a two year educational program before they are able to see patients. *If* postgraduate training is required, it may be for a period as short as eight to 16 weeks. The standardized, higher level of medical training that physicians receive, which far exceeds that of non-physician clinicians, is backed by decades of evidence showing that it uniquely prepares physicians to safely and independently deliver medical care to patients. Paradoxically, although states require physicians to carry significant malpractice liability insurance, the same requirements often do not apply to non-physician clinicians who receive less training and complete less testing than physicians, even in states that allow those individuals to autonomously provide "the same" or similar services as physicians. Nonetheless, it is because of these vast differences in clinician "resource costs" (education, training, technical skill, physical and mental effort, overhead, malpractice costs, etc.), that payment rates for physicians are higher.

We believe that mandating pay parity between physicians and non-physician clinicians of varied knowledge and skill levels will drive up the cost of healthcare and decrease access to affordable, high-quality care for patients. The financial burden on Medicare FFS and Medicare Advantage associated with increasing payment rates for non-physicians could be significant, and there may be additional costs resulting from a potential duplication of services and follow up visits with physicians resulting from initial care provided independently by non-physicians. For this reason, we urge you to support evidence-based scope of practice and rate-setting determinations, based on a clinician group's level of training, education, experience, and examination.

Sec. 6. Encouraging Innovation for Patients.

We are encouraged by the Administration's goal of bringing new and more effective treatments, devices, and services to patients faster. Efforts to streamline coverage decisions by CMS on FDA-approved therapies and devices will help physicians care for their patients and promote better health outcomes. Additionally, providing clarification for physicians and their teams on CMS standards for deciding appeals of coverage decisions and increasing transparency and efficiency for the National Coverage Determination process will also help free up physician time to care for their patients, and avoid unnecessary delays in care.

As CMS explores opportunities for improving patient access to effective treatments, we would encourage the inclusion of pain management innovations as alternatives to opioids in this discussion. We stands ready to work with CMS to address our nation's opioid epidemic and improve access to effective, evidence-based, non-pharmacological pain management modalities such as osteopathic manipulative treatment (OMT)[1]. Treating pain osteopathically is a viable solution for non-opioid pain management, and OMT has been recognized as an effective non-pharmacological therapy in 2017 Federation of State Medical Boards (FSMB) guidelines as well as 2019 American Medical Association (AMA) Opioid Task Force Recommendations.

We appreciate the opportunity to be a part of the effort to improve access to care and coverage, and improve health outcomes for our nation's seniors and other vulnerable Americans, and we look forward to working with you during the implementation of this Executive Order.

Sincerely,

American Osteopathic Association
American Academy of Osteopathy
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Neurologists and Psychiatrists
American Osteopathic College of Radiology
Arizona Osteopathic Medical Association
Florida Osteopathic Medical Association
Idaho Osteopathic Physician's Association
Indiana Osteopathic Association
Iowa Osteopathic Medical Association
Kentucky Osteopathic Medical Association
Louisiana Osteopathic Medical Association
Maine Osteopathic Association
Michigan Osteopathic Association
Minnesota Osteopathic Medical Society
Mississippi Osteopathic Medical Association
Missouri Association of Osteopathic Physicians and Surgeons
New Hampshire Osteopathic Association
New York State Osteopathic Medical Society
North Carolina Osteopathic Medical Association
Ohio Osteopathic Association
Oklahoma Osteopathic Association
Osteopathic Physicians and Surgeons of California
Osteopathic Physicians and Surgeons of Oregon
Pennsylvania Osteopathic Medical Association
South Carolina Osteopathic Medical Society
Tennessee Osteopathic Medical Association
Texas Osteopathic Medical Association
Virginia Osteopathic Medical Association
West Virginia Osteopathic Medical Association

[1] Franke, H., Franke, J.-D., & Fryer, G. (2014). Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders, 15, 286. http://doi.org/10.1186/1471-2474-15-286