AMERICAN OPTOMETRIC ASSOCIATION

January 25, 2018

John R. Graham
Acting Assistant Secretary
Assistant Secretary for Planning and Evaluation
Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Graham

The American Optometric Association (AOA) appreciates the opportunity to provide input on the Request for Information - Promoting Healthcare Choice and Competition Across the United States[1] issued by the Assistant Secretary for Planning and Evaluation (ASPE). The AOA represents approximately 33,000 doctors of optometry and optometry students. Doctors of optometry are eye and vision care professionals who diagnose, treat, and manage diseases, injuries and disorders of the eye, as well as surrounding tissues and visual system. Our members play a major role in patients' overall health and well-being by helping to detect and prevent complications of systemic diseases such as hypertension, cardiovascular disease, neurologic disease, and diabetes — the leading cause of acquired blindness.

Doctors of optometry serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities we are the only eye doctors available. Providing more than two-thirds of all primary eye and vision health care in the United States, doctors of optometry deliver up to 80 percent of all primary vision and eye health care provided through Medicaid. Recognized as Medicare physicians for more than 25 years, doctors of optometry provide medical eye care to nearly six million Medicare beneficiaries annually. The AOA also serves the needs of the public through the provision of evidence-based clinical practice guidelines — accessible by health professionals and laypersons alike — that promote prevention, identification, treatment, and management strategies for eye and vision conditions/diseases to improve the nation's health.

The AOA greatly appreciates your focus on reducing the Department of Health and Human Services' (HHS) regulatory burdens. We offer the following input to address that goal.

What State or Federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) reduce or restrict competition and choice in healthcare markets?

In the past, health plans have utilized anticompetitive tactics — such as discriminatory plan coverage and design, benefit limits, and enrollee cost-sharing — to deny or severely limit patient access to specific types of providers, even though those providers would be acting within the bounds of their training and scope of practice as statutorily defined by state law. To avoid this anti-competitive behavior, HHS should work to preserve, promote, and defend the pro-patient, pro-competitive provisions of Public Health

[1] https://aspe.hhs.gov/pdf-report/competition-rfi (Last Access January 24, 2017)

Service Act Section 2706 (the ACA's Non-discrimination in Health Care provision). Section 2706 is an important patient-centered health insurance reform and is aimed at safeguarding a patient's right to choose their doctor. Overall, Section 2706 aims to end certain health plan practices which have made it policy to summarily deny participation to a range of licensed and certified health care providers merely because those providers took a different educational path to clinical expertise, quality, and licensure.

Currently, some insurance providers require doctors to participate in restrictive insurance plans or networks which force doctors to accept discounts on noncovered services; require doctors to participate in a vision plan as a condition for participation in a medical plan and restrict a doctor's choice of a lab. These types of plan abuses lead to higher overall costs and limit patient access to the doctors of their choice. For doctors, many of whom operate small businesses, the plans dictate and intrude on what they charge for services not covered by the plan; force them to accept damaging terms for supplemental vision plans; and set which optical labs they can or cannot use to provide needed treatment to patients. Additionally, often the labs required for use are also owned by the plan. While 19 states have enacted legislation addressing these exploitations for plans regulated at the state level, better safeguards to prohibit these kinds of insurance practices would help to put patients and doctors — rather than health and vision plan executives — back in control of important health care decisions.

What suggestions do you have for policies or other solutions (including those pertaining to Medicare, Medicaid, and other sources of payment) to promote the development and operation of a more competitive healthcare system that provides high - quality care at affordable prices for the American people?

Complex regulatory frameworks and lengthy administrative processes, such as Medicare enrollment and quality payment programs, represent barriers to entering and participating in the marketplace. These burdens distract doctors from delivering high quality care to their patients. We offer the following examples of Medicare and Medicaid funding mechanisms that reduce or restrict competition and choice in healthcare markets.

Medicare Enrollment: On a very simple level, for patients to have adequate access to healthcare providers, doctors must be able to enroll in the Medicare program and start serving patients without significant delay. Currently, our doctors report that the enrollment and revalidation process can take months. During the process, doctors are frequently asked multiple times for the same information, have difficulty reaching a team member at Medicare contractors for guidance and will sometimes face delays in payment due to the burdensome nature of the enrollment process. These unnecessary hurdles and delays also occur for doctors who have been serving Medicare patients for years if they change practice locations or owners.

Medicare enrollment has many lengthy and complex administrative processes with no meaningful benefits. When enrolling in Medicare, many doctors are required to deal with several entities and programs, including the national supplier clearinghouse, the regional Medicare Administrative Contractor, Rail Road Medicare, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) contractors, and Medicare Advantage Organizations. Many of these programs require interacting with several portals — such as Provider Enrollment, Chain, Ownership System (PECOS) and CMS Enterprise. These entities all have different protocols and credentials that continually change. Many doctors need to spend significant resources and time to understand these complex and changing entities, protocols, policies and requirements. HHS should consider reducing the complexity and number of entities involved in enrolling in CMS programs. HHS should also consider requiring Medicare Advantage plans to use a centralized and more streamlined Medicare credentialing process.

Prior Authorization and Referrals: Many Medicare Advantage plans employ burdensome prior authorization processes that require doctors and patients to enter into a negotiation process to obtain authorization for a medication or procedure that a doctor has determined would be most effective for a patient. This process needlessly delays access to medication that patients need immediately. Some Medicare Advantage plans also require a referral for a patient to seek treatment from a doctor of optometry. All traditional Medicare beneficiaries have the right to direct access to doctors of optometry. The same direct access should be provided under Medicare Advantage plans. Medicare Advantage plans should be required to work with physicians to develop prior authorization processes which respect physician judgment and eliminate referral requirements that only serve as an impediment to care.

Patient Choice: In recent years, there has been an increase in Medicare Administrative Contractors (MACs) attempting to limit patient choice of physician through local coverage determinations. MACs should be prohibited from creating policies that attempt to limit patient choice by precluding certain physicians from providing certain services, despite the physician being licensed under state law to provide the service or treatment. Beneficiaries should have options to choose practices that best serve their medical needs. This will allow for greater competition and choice.

Medicare Part D Formulary: Currently, Medicare Part D policies limit competition among drug manufacturers and prevents patients from receiving the medication they need. For Medicare Part D, CMS creates a listing of medications (formulary reference file) that the agency recommends for coverage by Medicare Part D plans. The process to get a medication added to the formulary is time consuming and causes delays in patient access to necessary medications. For patients who would clinically be more successful on a particular type of medication that is not currently on the formulary, this process can stand in the way of ensuring Medicare beneficiaries are able to receive effective quality care. Regulatory reforms streamlining the process for adding drugs to the formulary will increase patient choice and encourage more competition among the drug market.

Thank you for your attention to the important issue of regulatory reform. If you have any questions, please contact AOA's Regulatory Policy Specialist, Jensen N. Jose, JD at jjose@aoa.org.

Sincerely,

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President, American Optometric Association