American Academy of PAs

August 31, 2022

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Request for Information on Medicare Advantage

Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 159,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage request for information (RFI). In response to the goals identified by CMS under the RFI, AAPA wishes to identify several opportunities to improve Medicare Advantage.

Medicare Advantage (MA), or Medicare Part C, is an alternative to Original Medicare's Part A (hospital) and Part B (medical) coverage. Implemented by private payers and funded by Medicare, these payers are granted flexibility in the development of plan policies and in the benefits they offer. While required to cover all services deemed medically necessary by Original Medicare, MA plans frequently offer attractive additional benefits such as prescription drug coverage (as an alternative to Medicare Part D), hearing and vision coverage, which are not covered services under Medicare Parts A and B.

However, while MA provides significant value for certain Medicare beneficiaries with the promise of lower premiums, deductibles and potentially more covered benefits, there are also several tradeoffs in electing an MA plan over Original Medicare. Some of these tradeoffs offer an opportunity for policy modifications that could improve the MA beneficiary experience.

Under the RFI, CMS is seeking feedback on methods to strengthen MA in ways that align with the agency's strategic pillars.[1] As such, the RFI breaks down its solicitation of comments into five general categories: Advancing Health Equity, Expanding Access for Coverage and Care, Driving Innovation, Supporting

[1] The Centers for Medicare and Medicaid Services. 2022. CMS Strategic Plan. Retrieved from https://www.cms.gov/cms-strategic-plan

Affordability and Sustainability, and Engaging Partners. AAPA has elected to provide our recommendations to improve MA plans according to these categories.

Advancing Health Equity

AAPA supports the goals of minimizing disparities and promoting equity in healthcare. As with Original Medicare, there are several opportunities to progress toward these goals under MA. One contributing factor hindering health equity is a disparity in access to care. Underserved populations disproportionately have impediments to accessing care. While access disparities are not unique to MA, narrow networks, frequently utilized under MA plans, may be a barrier to beneficiaries receiving care.[2] For those MA plans that are confined to one geographic area, care options within that area may be limited. To ensure patients can receive care in a timely manner, MA plans must be prevented from prohibiting the enrollment of entire categories of health professionals, especially those that can help address care deficiency gaps.

PAs can help reduce access limitations. The US health system faces a physician shortage.[3] As a result, PAs and nurse practitioners (NPs) are currently providing a substantial portion of the high-quality, cost-effective care that our communities require, and will continue to do so to meet the needs of their communities. As of 2017, there were more than 260,000 PAs and NPs billing for Medicare services. According to the Medicare Payment Advisory Commission (MedPAC) approximately half of all Medicare patients receive billable services from a PA or NP.[4] As noted by MedPAC, the number of Medicare beneficiaries being treated by PAs and NPs continues to grow. However, if PAs and NPs on whole are prevented from enrolling in a MA plan, or face policy constraints that prohibit them from providing care they are qualified to deliver, then these plans are unnecessarily constraining a powerful resource in their arsenal in addressing access disparities and advancing health equity.

AAPA recommends that CMS explicitly prohibit MA plans from excluding classes of health professionals so that health professionals, such as PAs, can provide medically necessary care. Provider enrollment decisions should be based on the needs of the patient population. Arbitrary exclusion of a class of health professional limits access.

AAPA also suggests that CMS ensure all services authorized to be performed by health professionals, such as PAs and NPs, under Original Medicare be similarly authorized under MA plans, subject to state law. This would serve to enhance access by ensuring that patients do not have to forgo or wait longer for services from a physician that PAs and NPs are qualified by education and training to provide.

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[2] Park S, Meyers DJ, Langellier BA. Health Affairs. 2021. Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare. Retrieved from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01435

[3] Association of American Medical Colleges. 2021. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.aamc.org/media/54681/download

[4] MedPAC June 2019 Report to Congress, page 151: http://medpac.gov/docs/defaultsource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

In addition to providing consistency across Original Medicare and MA in what services health professionals are authorized to perform, CMS may wish to eliminate remaining burdensome and unnecessary barriers to PA practice under both Original Medicare and MA. This would further support a PA's ability to improve patient access and thereby potentially reduce inequities. For example, in examining how the agency can bolster health equity under MA plans, CMS may wish to review responses to the RFI contained within its 2023 Physician Fee Schedule proposed rule regarding how to increase access to underutilized services, and apply feedback received to MA plans as well. In the RFI, CMS correctly emphasized that obstacles to Medicare beneficiaries accessing such services exacerbates health disparities and reduces equity of care. In AAPA's comments to the rule, we expressed a belief that PAs can ameliorate access limitations to high value, underutilized services. We identified a number of policy changes that would eliminate remaining burdensome and unnecessary barriers to care provision under Original Medicare such as authorizing PAs to order Medical Nutritional Therapy, perform current physician-only services in Inpatient Rehabilitation Facilities, order therapeutic (diabetic) shoes, perform colonoscopies, interpret screening mammography and electrocardiograms, certify terminal illness under the hospice benefit, order medications for hospice patients when employed by a hospice, and more. Each of these recommendations represents a function that, if provided by PAs, would increase the availability of an underutilized service, thereby advancing health equity. Consequently, we believe the stated authorizations should be granted under MA plans as well.

Finally, another method by which CMS may wish to promote equity under MA plans is to ensure transparency of care options. Participants in any health plan need to have access to information regarding care options available to them within their network. In concert with a requirement, proposed above, to not exclude a group of health professionals, such as PAs, from enrolling in a provider network, PAs should be specifically included in provider directories.

Expanding Access for Coverage and Care

Helping Beneficiaries Decide on the Right Care Option

In the RFI, CMS poses the question of what tools beneficiaries may need to choose between Medicare coverage options (Original Medicare vs. varying MA plans). As MA plans must accept all eligible Medicare beneficiaries, including those most sick and costly, these plans attempt to control costs by charging sometimes large copayments for certain services. Although MA plans also feature an out-of-pocket payment limit, specific to the plan, the limit may sometimes be quite high, and care can be expensive for beneficiaries prior to meeting the limit. This sometimes-high level of cost sharing could result in coverage being more expensive under MA plans,[5] but for others care may be more expensive under Original Medicare. The answer to which is a better value for beneficiaries will be a result of expected level of usage of services, as well as the types of services used. Consequently, AAPA recommends that CMS develop an easily usable cost calculator that can help beneficiaries develop an approximation of expected annual out-of-pocket costs for the respective MA plans, beyond premiums. An individual would be able to assess different scenarios regarding

[5] Neuman T, Damico A, Cubanski J. Kaiser Family Foundation. 2020. How Much Could Medicare Beneficiaries Pay For a Hospital Stay Related to COVID-19? Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/how-much-could-medicare-beneficiaries-pay-for-a-hospital-stay-related-to-covid-19/

their expected frequency and type of care used and receive a comparison of Original Medicare versus an MA plan selected. AAPA further recommends a compulsory easily navigable provider search option, viewable prior to selecting an MA plan, which includes all available care options (as recommended above) and would give beneficiaries additional data to determine if the network provided meets their individual needs. Finally, AAPA further believes that an easily understandable one-page document, highlighting the various differences between Original Medicare and MA, would be a well-utilized resource as well.

Increasing Behavioral Health Access Under MA Plans

Under this section of the RFI, CMS inquires as to what steps CMS should take to ensure beneficiary access to behavioral health coverage under MA. AAPA notes that behavioral health is experiencing worsening physician shortages at the same time as it is seeing increasing demand for services. Sixty percent of US counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health treatment and contributing to inadequate care and unsafe conditions.[6] A recent New York University study found that while demand for mental health services is increasing, patient access is decreasing.[7] Untreated mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.[8] The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than needed to meet the demand for services.[9] The National Council for Behavioral Health expects that, by 2025, there will be a deficit of 12% in the psychiatric workforce to sufficiently address patient needs.[10] An inadequate supply of providers of mental health services may lead to delays in diagnosis and care, rationing of resources, ineffective care, and increased negative consequences of mental illness and substance use.[11] These problems will be even more severe in rural and underserved communities.

More will need to be done to encourage non-MD/DO health professionals to fill some of the care gaps due to shortages in psychiatrists and increased demand. PAs and other qualified health professionals must be authorized to practice to the fullest extent of their license and training. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

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[6] Substance Abuse and Mental Health Services Administration. 2019. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[7] Heath, Sara. PatientEngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. Retrieved from https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows

[8] Mayo Clinic. 2019. Mental Illness. Retrieved from https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968#:~:text=Untreated%20mental%20illness%20can%20cause,Family%20conflicts

[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. Rockville, Maryland. Retrieved from https://www.hrsa.gov

[10] National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. Retrieved from https://www.thenationalcouncil.org

[11] Ibid

PAs are trained and qualified to treat mental and behavioral health conditions through their medical education, including extensive didactic instruction and supervised clinical practice experience in psychiatry. They must achieve national certification in order to be state licensed and are authorized to prescribe controlled and non-controlled medications.[12] PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral health services. Based on their Master's degree education, PAs practicing in mental health and substance use treatment can expand access to necessary care. PA education includes thousands of hours of didactic and clinical practice experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties providing a foundation to address the diverse medical needs of people with mental illness or substance use issues.[13]

PAs conduct histories and physical examinations; perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans, and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often providing care in rural and public hospitals where there are inadequate numbers of psychiatrists.[14] In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs, working in collaboration with physicians and other members of the healthcare team, have been demonstrated to improve access to care with high levels of quality and patient satisfaction that is similar to that of physicians.[15] Authorizing PAs to deliver this high-quality care to patients can help alleviate ongoing and worsening trends in access to behavioral and mental health services.

PAs are qualified to meet behavioral health access challenges, both under Original Medicare and MA. The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics, with a projected 31% increase in PAs from 2018 to 2028.[16] The recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st

[12] American Academy of PAs. What is a PA? Retrieved from https://www.aapa.org/what-is-a-pa/
[13] Ibid
[14] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. *American Journal of Preventive Medicine.* 2018. Geographic variation in the supply of selected behavioral health providers. Retrieved from https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext.
[15] Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from https://www.medpac.gov
[16] U.S. Bureau of Labor and Statistics. 2020. Occupational outlook handbook: Physician assistants. Retrieved from https://bls.gov

Century Cures Act,[17] CMS' inclusion of PAs as authorized providers in community mental health centers,[18] and the establishment of PAs as mental and behavioral health providers at the state level.

There are approximately 2,300 PAs practice in psychiatry. This number has remained low due to restrictions placed on PAs in this specialty by some private payers. Some of these payers may be those that are implementing MA plans and thus have similarly restrictive policies under the MA options they offer to beneficiaries.

AAPA proposes that CMS require that private payers offering MA plans cover PA-provided behavioral and mental health services under these plans similar to Original Medicare. The elimination of prohibitive policies pertaining to PAs providing behavioral health under MA plans would enhance access to quality care in a specialty that is suffering from workforce shortages and increased demand.

Other Considerations to Bolster Patient Access to Care under MA Plans

CMS can take further action to ensure that MA plans do not perpetuate restrictive policies that may encumber patient access. For example, MA plans should ensure there are no unnecessary policy restrictions on telehealth usage or EHR functionality. The ability to provide telehealth services helps meet patients where they are, enhancing access for potentially underserved populations such as those with transportation or mobility challenges, or those in rural areas with no easily accessible source for medical care. Meanwhile, requiring that EHR technology have full functionality for all health professionals who deliver medical care, including PAs, would allow such health professionals to provide care that is coordinated, timely and transparent.

AAPA further believes CMS should ensure that utilization management requirements employed by MA plans, when used, are applied uniformly. MA plans frequently require prior authorizations/referral review as a cost-saving mechanism.[19] AAPA believes requirements for seeking prior authorization should be standard across all categories of health professionals. In addition, CMS should encourage MA plans to develop methods that would streamline the time necessary for prior authorizations responses and use data analysis on prior authorizations to determine whether the policy is improving health outcomes or is merely being used to deter care.

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[17] 21st Century Cures Act. Public Law No: 114-255 2016. Retrieved from https://www.congress.gov/bill/114th-congress/house-bill/34/text

[18] Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. Retrieved from https://www.law.cornell.edu/cfr/text/42/485.904

[19] Wang, Penelope. Consumer Reports. 2021. The Pros and Cons of Medicare Advantage. Retrieved from https://www.consumerreports.org/medicare/pros-and-cons-of-medicare-advantage-a6834167849/

Driving Innovation

AAPA believes there are many tools CMS can use to foster innovation under MA. For example, nearly all Center for Medicare and Medicaid Innovation (CMMI) models apply to Original Medicare.[20] AAPA recommends the creation of models that apply to MA plans or making a determination that CMMI models also apply to MA plans, allowing for creativity in reimbursement and health delivery methods.

In the RFI, CMS asks for examples of "payment or service delivery models," that CMMI could "test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care." AAPA suggests that, to reduce costs, some MA plans may wish to undertake efforts to prevent the more expensive care interventions that occur later in a disease's progression by better incentivizing and utilizing primary care. According to a report from the Health Resources and Services Administration (HRSA), the US health system faces a clinician shortage, particularly in primary care.[21] A shortage in the primary care workforce may lead to insufficient patient access to needed healthcare services and the need for more intensive and high-cost interventions such as hospitalization or emergency care.[22] A decrease in the availability of primary care may also lead to a less equitable supply of healthcare services.[23] Future CMMI models that apply to MA plans may choose to use their flexibility to modify existing funding mechanisms to increase payment and/or explore innovative payment models for primary care services to make practice in the specialty more attractive to current and future practicing health professionals. A similar monetary incentive may be in the form of loan repayment assistance in exchange for a certain number of years practiced in primary care. Other models may choose to increase the autonomy of health professionals practicing in primary care by eliminating burdensome Medicare practice requirements.

The same HRSA report acknowledges the growing PA and NP professions as providing an opportunity to alleviate the effects of a physician shortage if interested health professionals are successfully assimilated into the delivery system for primary care.[24] Consequently, another suggestion is to experiment with significant changes to reimbursement structures under CMMI, testing policy changes such as 100% reimbursement for PAs and NPs when providing primary care.

In the RFI, CMS also questions whether there are innovations, "CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum." Another example of a potential model for MA plans would be one focused on hospice innovations. Currently, Original Medicare has restrictive policies pertaining to PAs employed by a hospice,

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[20] Kaiser Family Foundation. 2018. "What is CMMI?" and 11 other FAQs about the CMS Innovation Center. Retrieved from https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/#:~:text=The%20VBID%20model%20allows%20Medicare,to%2025%20states%20in%202019.
[21] Westat. 2015. Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. Retrieved from: https://aspe.hhs.gov/reports/impact-state-scope-practice-laws-other-factors-practice-supply-primary-care-nurse-practitioners
[22] Shi, Leiyu. 2012. The impact of primary care: a focused review. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/24278694/
[23] IBID
[24] Westat (n 19)

restricting them from ordering medications for hospice patients or acting in the role of an attending physician if a patient had not chosen one before arriving at a hospice. There are also statutory restrictions on PAs that would benefit from a model demonstrating the value of their removal. For example, removing prohibitions on PAs certifying terminal illness or on providing the required face-to-face visit prior to recertification of hospice would likely improve initial and ongoing access to hospice care, minimizing patient suffering and possibly reducing costs from attempts at care that will not be curative

AAPA suggests that, outside of CMMI, CMS may consider creating an "innovation bonus" for MA plans that seek to be their own "experimental model" by testing and sharing unique concepts that increase access while decreasing patient cost. The agency may also wish to encourage further alignment between ACOs and MA plans by urging consistency in quality metrics, methods of data collection, data exchange, and data requirements. This will ease administrative burdens on health professionals and potentially make data easier to compare for beneficiaries.

CMS poses the question regarding how MA plans work with providers to engage on value-based care. AAPA is interested to learn what responses from MA plans CMS receives to this question. We urge CMS to publish a summary of its responses to this question so that health professionals and those who represent them may better be able to interact with individual plans according to their preferred method of receiving feedback.

Finally, under this section of the RFI, CMS asks how the agency could better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data. AAPA strongly believes in the potential of data to improve care provision. However, to ensure optimal benefit, MA plans must be able to rely on the data they collect. For this reason, AAPA would advocate that CMS prohibit MA plans from utilizing billing or reporting methods that obscure PAs and NPs. When services provided by these health professionals are billed under a physician with whom they work there is a lack of transparency and the data collected can result in false and inaccurate analysis.

Supporting Affordability and Sustainability

In this section of the RFI, CMS asks the question, "As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?" AAPA believes the increasing popularity of MA plans only magnifies the need for consistency in policies pertaining to health professionals between Original Medicare and MA. AAPA is concerned that wide variations in policies between plans may cause confusion among health professionals who are most familiar with the coverage policies of Original Medicare. AAPA believes standardization of certain policies, such as those mentioned earlier, may be beneficial in creating operational consistency across the Medicare program while still allowing flexibility in the array of additional benefits being offered and reduced beneficiary cost sharing under MA.

Engaging Partners

Finally, CMS wants to know what more the agency can do to engage partners and stakeholders to continue to improve MA. AAPA recommends that CMS educate the various stakeholders about the flexibilities afforded to MA plans based on their contractual agreement with the Medicare program, and detailing requirements CMS can place upon private payers as they develop and implement MA plans. A better understanding will foster a more informed discussion regarding the capabilities of CMS to incentivize increased equity, access, and innovation. In addition to CMS educating stakeholders, we request the agency also seek more opportunities for feedback from health professionals as to what may help reduce practice burdens under MA. While RFIs are useful, the most effective method of communication includes personal meetings with representatives of various medical societies, as this would allow for an expedited exchange of information. As such, AAPA would appreciate a meeting in the near future with CMS officials on the issues raised in this RFI and how PAs can better assist MA plans in meeting the goals identified by the agency.

Thank you for the opportunity to provide feedback on the Medicare Advantage request for information. AAPA welcomes further discussion with CMS regarding these issues. For any questions you may have please do not hesitate to contact me at michael@aapa.org.

Sincerely,

Michael L. Powe
Vice President
Reimbursement & Professional Advocacy