May 29, 2024

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

RE: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 168,300 PAs (physician assistants/associates) throughout the United States, would like to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage request for information (RFI). The RFI solicits broad feedback on all aspects of data relating to the Medicare Advantage (MA) program. As PAs currently provide hundreds of million patient visits each year, many which are with Medicare beneficiaries, AAPA wishes to identify several considerations for MA data usage and collection.

AAPA supports high standards for robust and accurate data. We believe the level of data collected under MA should be at least as high as Original Medicare, if not higher, as MA plans are being implemented by a non-governmental third party, and proper stewardship of the program must be ensured. In the RFI, CMS provides numerous examples of the breadth of information it is requesting regarding MA data. Some examples noted include data-related recommendations regarding beneficiary access to care, prior authorization/utilization management, cost and utilization of supplemental benefits, and more. It is for this reason that AAPA has organized our comments according to topic.

Using MA Data to Improve Beneficiary Access

AAPA believes in the potential value of data in supporting MA beneficiary access to care. Specifically, we believe that increased beneficiary access can be achieved by employing data to make better decisions regarding provider utilization. AAPA observes the correlation between MA data, provider utilization, and beneficiary access in several ways.

First, MA data can help identify both geographic locations that are facing a provider shortage, as well as provider specialties that do not have a sufficient number of health professionals to meet MA beneficiary demand. With this information, CMS can modify provider network adequacy requirements to meet demand, and MA plans can use data to target these gaps in care availability by incentivizing participation of health professionals that may augment beneficiary access. PAs, as health professionals who practice across various specialties, can help meet current shortages between healthcare supply and demand, but accurate data must be collected to identify those communities and medical specialties where shortages exist.

Second, MA data on provider scope of practice restrictions can be used to identify which MA plans are more restrictive than Original Medicare. This is especially relevant for non-physician health professionals, such as PAs and nurse practitioners (NPs), who currently, and will continue to, help meet demand for care. For PAs and NPs to amply contribute to meeting the needs of MA beneficiaries, PAs and NPs must not have unnecessary restrictions placed on them regarding the type of care they are authorized to provide. If available health professionals who are qualified to provide a service are prohibited from doing so, beneficiaries may have to wait longer for necessary care. With this information, CMS can meet with MA plans to communicate how superfluous restrictions beyond state law may inhibit beneficiary access to services.

Third, data on which services are being provided to MA beneficiaries, and the volume of those services, can help identify "underutilized services" under MA. CMS had previously identified numerous "underutilized services" under Original Medicare. If underutilized services can be identified under MA, CMS would then be able to determine whether there's an intersection between Original Medicare and MA plans regarding what types of services are not being sufficiently utilized. With this information, CMS could reexamine responses received to an RFI contained in its 2023 Physician Fee Schedule[1] that explicitly asked for feedback on how to increase usage of high value services that are potentially being underutilized by Medicare beneficiaries. In that rule, CMS identified a number of examples of what it considers high value, underutilized services, including preventive services, care management, trainings, screenings, rehabilitation services, therapies, treatments programs, assessments, and more. As AAPA noted at the time, there are myriad reasons why these services are underutilized, from situational workforce shortages, policy impediments, and transportation, to cost, coverage limitations, and lack of knowledge about their existence, to name a few. There's no reason to believe that these services and their underlying reasons for underutilization are not also applicable to MA plans. Consequently, examining which services are being underutilized under MA can help CMS and its MA plan partners implement some of the takeaways it learned from its 2022 RFI.

AAPA would find information on underutilized services under MA valuable as well, as it would further inform a discussion as to how PAs are able to help ameliorate limitations on access to high value, underutilized care. Specifically, CMS could use data collected on the underutilization of services under MA, in conjunction with data on which plans are most restrictive of services being provided by non-physician health professionals, to determine whether there's a correlation regarding ongoing restrictions on PAs providing certain services and patients not receiving those services at the volume determined optimal by CMS.

[1] https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

Fourth, MA data can provide information regarding care quality, market competition and health equity to receive an overall picture of MA beneficiary access to quality care. Using this information in conjunction with data on PA scope restrictions could help CMS determine if any differentiation between Original Medicare and MA treatment of non-physician health professionals is negatively impacting these quality metrics.

Finally, MA data on who is providing what types of services to beneficiaries may contribute to more accurate provider directories. CMS has recognized the inadequate state of provider directories as recently as its 2022 RFI[2] on the subject, noting that provider directories in their current form often display inaccurate or redundant information and are often missing essential information that may be valuable to beneficiaries/patients. AAPA believes the value of provider directories is in helping beneficiaries identify both those providers who are available to provide care, as well as those most suited for their care needs. Consequently, provider directories are most successful when the information contained in them is complete, accurate, and navigable.

Currently, some provider directories omit information that would alert beneficiaries to all available care options. For example, while not always the case, PAs are occasionally omitted from a payer's provider directory. As essential members of healthcare teams, PAs must be specifically included in all payer provider directories. However, even when PAs are included in provider directories, there is a potential for incomplete information to be made available that hinders beneficiary choice and access. Provider directories are typically designed so that a beneficiary is prompted to search for a potential provider based upon the alignment of their care need and the specialty in which a provider practices. PAs are often not enrolled with payers in a particular specialty and, consequently, are not listed in many provider directories under the specialty in which they practice. Instead, PAs are often listed in provider directories under the generic category of "physician assistant" or "PA." If a beneficiary is looking for care in dermatology, a PA who practices in dermatology may not be identified in the directory as a dermatology provider. The beneficiary may instead select a provider specifically listed under the category of dermatology who might be located a greater distance from the beneficiary and/or have substantially longer wait times, both of which create access issues for beneficiaries. To remedy this situation, PAs should be identified in provider directories under the specialty in which they practice and not placed into a "physician assistant" or "PA" category. This can be accomplished by authorizing PAs to report the specialty/specialties in which they practice to the MA plan.

One of the core principles of the PA profession is flexibility and the ability to change practice specialties. This flexibility is essential in helping to meet the rapidly changing healthcare needs of patients. Unlike physicians, who are typically board certified in a particular specialty, PAs are nationally certified to practice medicine. The profession's comprehensive, generalist medical education, training and preparation give PAs the capability and expertise to practice in different specialties and change specialties in response to the changing healthcare needs of patient populations. Maintaining this practice flexibility is especially important because of 1) challenges facing the healthcare workforce, including the current and growing shortage of physicians and the increasing problem of losing health professionals due to provider burnout; 2) the need to deliver

[22] https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services

increased access to care for patients in rural and underserved communities; and 3) the necessity to rapidly respond to future public health emergencies. Authorizing PAs to report their practice specialty to the MA plans will improve provider directory transparency, make beneficiaries aware of all available care options, and support the PA profession's continued ability to meet the evolving needs of the US healthcare delivery system.

Provider directories should be made available to beneficiaries prior to selection of an MA plan, so that the beneficiary who is changing coverage may be able to determine whether medical professionals they wish to retain are covered by the MA network they are considering.

Additional Uses for Collected Data

Robust and complete MA data is useful beyond its applications to improve beneficiary access. One additional benefit to MA beneficiaries is oversight of levels of patient satisfaction and costs.

Data on patient costs could also be utilized to create a new tool that will help educate prospective beneficiaries on their total out-of-pocket expenses. AAPA recommends the development of an easily usable cost calculator that takes into account beneficiary costs beyond premiums in order to give a more holistic perspective on expenses. Such a calculator could allow individuals to assess different scenarios regarding their expected frequency and type of care used and receive a cost/value comparison of Original Medicare versus a selected MA plan.

The same data on patient satisfaction, costs, and access can also be used to chart the future of MA service and delivery models. The ability of CMS to compare the policies of various MA plans that lead to differing levels of satisfaction, prices, and access can provide the agency with a list of policies that would benefit from further examination as a service delivery model. The success of those models in expanding access, reducing costs, and increasing patient satisfaction may then benefit the MA program on whole if policies tested in models are demonstrated to be successful and then implemented more broadly.

Nearly all Center for Medicare and Medicaid Innovation (CMMI) models apply to Original Medicare.[3] AAPA recommends the agency create models that apply to MA plans, or otherwise determine that CMMI models also apply to MA plans. Below are examples of potential models that could be implemented by CMS, or by the MA plans themselves, to generate data on reducing costs and increasing patient satisfaction.

> Model Example 1: Promoting Primary Care
> 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

[3] 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-innovationcenter/#:~:text=The%20VBID%20model%20allows%20Medicare,to%2025%20states%20in%202019

Administration (HRSA), the US health system faces a clinician shortage, particularly in primary care.[4] 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.[5] A decrease in the availability of primary care may also lead to a less equitable supply of healthcare services.[6] 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 noted above 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.[7] 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.

Model Example 2: Supporting Hospice Care Innovations

Currently, Original Medicare has restrictive policies pertaining to PAs employed by a hospice, 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.

MA data may also be used in a way that improves the experience of participating health professionals. One such way is to simplify the prior authorization process. The first way MA data can do this is by helping determine when prior authorization is required. CMS could analyze data on prior authorizations to determine in which instances the policy is improving health outcomes/reducing costs, and in which it is merely being used to deter care. A second way MA data can simplify prior authorization is through data usage to enhance automation of the prior authorization process, similar to those proposals mentioned in

[4] 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-practicelaws-other-factors-practice-supply-primary-care-nurse-practitioners
[5] Shi, Leiyu. 2012. The impact of primary care: a focused review. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/24278694/
[6] IBID
[7] Westat (n 4)

CMS's recently released Interoperability and Prior Authorization final rule.[8] Both of these uses of data to improve the prior authorization process will assist health professionals in providing necessary care in a more efficient manner.

A second way MA data may benefit health professionals is in assessments of provider satisfaction. Surveys attempting to determine provider satisfaction may identify directly to MA plans any problem areas that need to be addressed in order to maintain a robust network of health professionals.

The Importance of Data Transparency

AAPA strongly believes in the potential of data collection and utilization to improve care provision. However, to ensure optimal benefit, it is necessary for collected data to be accurate and complete. If MA plans do not enroll and hence recognize the ability of PAs or NPs to submit claims, or if MA plans are authorized to use billing or reporting methods that obscure PA and NP contributions, the usefulness of the data diminishes. MA plans must enroll PAs and NPs and require all services provided by these health professionals to be appropriately attributed to them, as opposed to a physician with whom they work. A more accurate depiction of who is providing what care will allow CMS to sufficiently determine provider care quality, what types of services are being provided by what types of professionals, and to whom each health professional is providing care. Only then can the benefits noted in the above sections be fully actualized.

Ensuring Proper Data Submission and Utilization

In an RFI that requests information on aspects of MA data, it is insufficient to merely extol the potential uses of data that can be collected. AAPA believes it is also necessary to note the importance of ensuring an unobstructive data collection process. Specifically, there must not be restrictions on the types of health professionals who can submit data. Such restrictions could exist as a policy of an MA plan or be due to the design of electronic health records. Whether and where such obstacles exist should be identified and removed in order to ensure that necessary data submission is not lost. Similarly, there should not be limitations on the types of health professionals who are authorized to access/utilize data. To realize many of the benefits listed above, health professionals such as PAs and NPs must be able to retrieve necessary information on individual patients, as well as any data communications sent by the MA plan itself.

Another method of supporting data submission would be to simplify the process by aligning, when possible, MA data submission with other data submission requirements, such as data submission protocols and standards for Accountable Care Organizations. Maximizing alignment of submission processes and requirements will reduce the number of different standards that health professionals and plans are required to meet.

[8] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

The Scope of Data Considerations

In the RFI, CMS stated that it is interested in ways the agency could leverage existing private sector data. AAPA notes that many of the benefits suggested in our comments can be similarly used for the betterment of beneficiaries under state and federal exchange plans. Consequently, we recommend CMS explore similar data requirements and uses for commercial payers with whom CMS partners. An expanded pool of data on similar topics will also aid in payer comparability of policies and performance.

Thank you for the opportunity to provide comments regarding the 2024 MA Data proposed rule. AAPA welcomes further discussion with CMS regarding these important 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 and Professional Advocacy