January 14, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW Washington, DC 20201

Re: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 123,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicaid managed care transparency, flexibility, and burden reduction proposed rule.

AAPA understands the need to reduce administrative burdens and increase the ability of states to utilize flexibility and innovation in their respective Medicaid programs. We support efforts aimed at giving states more control over how healthcare is delivered as long as states are committed to implementing rules and programs that expand competition in the marketplace, increase patient access to care, and improve transparency and efficiency.

The Departments of Health and Human Services, Treasury and Labor, along with the Federal Trade Commission and other administration stakeholders, recently issued a report entitled Reforming America's Healthcare System Through Choice and Competition which focuses on the impact of federal and state policies on choice and competition in healthcare markets. The report suggests that, in order to develop a better functioning healthcare market, states should consider eliminating 1) requirements for rigid collaborative practice and supervision agreements between physicians and PAs, and 2) statutes and rules that unnecessarily limit services PAs and other professionals can offer. Additional details on the report's recommendations regarding PAs are highlighted later in our comments.
A "one size fits all" approach to healthcare is rarely effective. Individual states are in the best position to determine optimal healthcare delivery based on their needs and circumstances, including unique access issues, patient populations and available resources. As the Centers for Medicare and Medicaid Services (CMS) strives to be less prescriptive with requirements for Medicaid managed care, AAPA suggests that CMS implement and promote best practices that will enable both state and federal government to enhance healthcare delivery. AAPA has identified several such best practices related to PA practice for Medicaid managed care below.

Best Practices to Promote Transparency, Efficiency and Access

Enroll, Credential, and Reimburse PAs in the Same Way as Physicians

PAs can provide services to Medicaid patients in all 50 states and the District of Columbia and, at a minimum, are required to be enrolled as "ordering and referring providers" by Medicaid fee-for-service programs. In forty-four states and the District of Columbia, PAs are enrolled as "rendering

providers" under the Medicaid fee-for-service program, which permits PAs to include their names and National Provider Identification (NPI) numbers on claim forms in a section that identifies who provided the service. However, under Medicaid fee-for-service in six states, PA-provided services are billed under and attributed to the collaborating physician. Traditionally, state Medicaid managed care plans are given additional flexibility to promulgate their own policies regarding whether PAs are enrolled as rendering providers. As such, a number of Medicaid managed care programs still do not enroll PAs as rendering providers and instead expect services provided by PAs to be billed under, and attributed to, the PA's collaborating physician.

When this occurs, the ability to track the services PAs deliver to patients is lost, and with it the ability to measure the volume of services or the quality of care delivered by PAs. The Kaiser Family Foundation notes that, "Nearly all states have managed care quality initiatives in place such as pay for performance or capitation withholds."[1] Due to this lack of recognition, attribution data collected by Medicaid programs that may be used to conduct analyses, make policy decisions regarding network and workforce adequacy, and support quality initiatives are distorted. Furthermore, this practice may cause patient confusion due to improper attribution of health professional services on an Explanation of Benefits to a physician the patient did not see and lead to the patient spending time trying to clarify the inaccurate information. Consequently, Medicaid managed care programs should require that, for services provided by PAs, claims be submitted identifying the provider who actually rendered the service.

Some state Medicaid programs and managed care plans require payment for professional services provided by PAs in hospitals be included in a facility fee paid to the hospital. In this scenario, individual professional services delivered by PAs are not reimbursed and often not tracked. If PAs are not permitted to separately submit claims for the services they provide in a hospital, then important data on those services cannot be captured and used for analysis and decision-making. Therefore, submitting claims separately for services provided by hospital-employed PAs, consistent with the practice of Medicare and many private payers, facilitates transparency.

Include PAs in Provider Directories

Not all Medicaid programs list PAs in their provider directories. The exclusion of PAs from provider directories impairs patient access as it prevents patients from possessing complete information to make informed care-delivery choices. It is vital beneficiaries receive complete information from their Medicaid managed care plan about their available network of providers so they can determine the best coverage and care options. Information on care availability is particularly important in rural or underserved areas, and for plans with limited networks. In order to maximize accessibility, beneficiaries must be able to search for PAs in provider directories in a similar manner as physicians.

Eliminate Unnecessary Supervisory or Collaborative Requirements Placed on PAs

In a December 2018 report, Reforming America's Healthcare System Through Choice and Competition,[2] the administration identifies several recommendations to modify current scope of

[1] https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state- medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/

[2] Reforming America's Healthcare System Through Choice and Competition (https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf), Released December 2018

practice policies. Among them, one stated: "States should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and dentists and their care extenders (e.g., physician assistants, hygienists) that are not justified by legitimate health and safety concerns."

AAPA agrees with this assessment. Many Medicaid programs, both in fee-for-service and under Medicaid managed care plans, place unnecessary supervisory requirements on PA practice, such as that a physician must be on site when a PA delivers care or that a physician must co-sign for select services provided by PAs. In most cases, such supervisory requirements are unnecessary and excessive, as PAs can provide quality care within their scope of practice under state-law levels of supervision. In fact, these unreasonable supervisory requirements can frequently be detrimental to care. Unreasonable supervisory requirements are inefficient uses of time for both the physician and the PA who may have to pause care to fulfill such administrative obligations. Further inefficiencies may arise from situations in which a patient's receipt of timely care is jeopardized due to burdensome supervisory obstacles, causing the patient's condition to worsen.

The report goes on to recommend that, "States should consider changes to their scope-of- practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set."

AAPA approves of this suggestion. We interpret this recommendation to indicate that, not only should states refrain from overly-restrictive laws and regulations that limit the practice of PAs, but also insurers should not place constraints on health professionals that enforce limitations beyond state law that effectively decrease a PA's ability and efficiency in providing care. Some Medicaid managed care plans, like some fee-for-service Medicaid plans, currently enforce limitations on a PA's scope of practice beyond state law, such as restrictions on ordering durable medical equipment, acting as an assistant at surgery, providing psychiatric care, and providing substance abuse treatment.

Tighter restrictions reduce the ability of PAs in such states to provide a greater array of care services to their patients. The Kaiser Family Foundation indicates that Medicaid plans consider shortages in available providers to be a significant challenge to network adequacy.[3] In a time of worsening physician shortage, these limitations may reduce patient access to necessary care, or prolong a patient's experience by requiring a PA to outsource services they are qualified to provide themselves to a physician unfamiliar with a patient's condition.

Reimburse PAs Directly When Their Benefits Are Not Reassigned to an Employer

The same report on choice and competition indicates, "The federal government and states should consider accompanying legislative and administrative proposals to allow non- physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care."

AAPA concurs with the administration's recommendation. Most health professionals have reimbursement reassigned to their employer as a condition of employment, but, if they do not have an employer, are able to receive payment directly. PAs are not given the option, as they are required to have an employer to receive reimbursement for their services. This constrains the flexibility of PA

[3] https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-executive-summary/

employment relationships as they are similarly unable to reassign benefits to other employers, as physicians and NPs can, in order to provide care in certain settings. While some Medicaid managed care plans, unlike Medicare or most Medicaid fee-for-service programs, do directly reimburse PAs for services, most do not. Direct payment of PAs can decrease administrative burden as health systems and insurers would not have to comply with and implement differing sets of rules and requirements dependent on provider type.

Reimburse Health Professionals at Rates that are Equitable to Encourage Participation in Medicaid Programs

Practices that do not feel as if they receive adequate reimbursement for services provided by the health professionals they employ may be hesitant to accept patients covered by low-reimbursement insurers. Medicaid managed care plans and Medicaid fee-for-service plans provide coverage for vulnerable patient populations. In order to safeguard these populations, Medicaid managed care plans should reimburse health professionals such as physicians, PAs, and Advanced Practice Registered Nurses, at fair levels for the care they provide to the Medicaid population.

Recognize PAs as Primary Care Providers

Some state Medicaid managed care plans do not recognize PAs as primary care providers (PCPs). This has negative implications for patient access as patients may not be aware of PAs in their communities who are available to provide their medical care. Those same patients may travel longer distances to receive care from another health professional who is listed as a PCP or, even worse, delay or fail to seek care. In addition, not identifying PAs as PCPs may require patients to pay more in order to see them. Certain health plans charge patients a lower co-payment when they receive primary care services from a PCP. If PAs are not designated as PCPs, patients can be required to pay a higher deductible or co-pay when receiving care from PAs, even when PAs are providing primary care services. This is unfair to patients and diminishes the incentive to encourage patients to seek primary care services.

In addition, the proposed rule allows states increased flexibility in setting network adequacy standards to be met by Medicaid managed care plans. AAPA believes that any network adequacy standards imposed on Medicaid managed care plans should permit such plans to identify all care providers when assessing care availability and identify PAs as primary care providers.

Thank you for the opportunity to provide feedback on the Medicaid managed care proposed rule. AAPA welcomes further discussion with CMS regarding our comments and recommendations. For any questions you may have regarding our comments please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

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President and Chair of the Board