



July 3, 2023

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: Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality - Medicaid Program; Ensuring Access to Medicaid Services - Attention: CMS-2439-P, CMS-2442-P

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 Medicaid access proposed rules. As many of the policies proposed under the two rules have implications for both fee-for-service and Medicaid managed care, AAPA will provide comments on both proposed rules under this comment letter.

A central theme of both rules is identifying methods by which the Centers for Medicare & Medicaid Services (CMS) can ensure and/or encourage increased patient access to needed Medicaid services. PAs can play an integral role in this effort by increasing patient access to medically necessary services and especially in underserved communities. A large number of patients, especially those in underserved communities, rely on PAs for medical care. According to the Medicare Payment Advisory Commission (MedPAC) approximately half of all Medicare patients receive billable services from a PA (or APRN), and that number continues to grow.¹ The removal of unnecessary restrictions currently placed on PA practice may bolster timely and equitable access to appropriate care. It is within this context that we draw your attention to our comments below.

¹ https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19-medpac-reporttocongress_sec-pdf/

Enhancing Access to Care for Medicaid Beneficiaries

AAPA believes that access to care is an important, but insufficient goal. As CMS indicated in its Medicaid access proposed rules, access to care must be both timely and equitable. As such, AAPA would like to comment on both important qualifiers first before proposing solutions in which the PA profession can help mitigate persisting access deficiencies.

Timely Access to Care for Medicaid Beneficiaries

As noted in the proposed rules, in response to a 2022 Request for Information, CMS received significant feedback regarding barriers to accessing care under Medicaid. Barriers frequently noted by respondents included providers not accepting Medicaid and the persistence of narrow networks. These barriers to beneficiary access are further exacerbated by worsening physician shortages. A report by The Association of American Medical Colleges estimates that workforce shortages are expected to increase and that by 2034 there will be a shortage of between 37,800 and 124,000 physicians.² Fewer health professionals will result in fewer care options for beneficiaries and may translate to long wait times to receive care.

In the proposed rules, CMS seeks to directly address the issue of wait times by proposing to set national standards. While AAPA chooses not to comment directly on what the appropriate upper limit of time for a beneficiary to obtain an appointment should be, we advise that the setting of such a boundary may not sufficiently address the underlying cause of current long wait times: a dearth of care professionals able to meet demand. Consequently, we suggest that wait times may be reduced by broadening the pool of health professionals authorized to provide needed services.

While PAs cannot completely solve the growing shortage of health professionals, a more efficient utilization of PAs can help mitigate health workforce scarcity. According to the Bureau of Labor Statistics, the PA profession is projected to increase in size 28 percent from 2021 to 2031, making it one of the fastest growing occupations.³ However, PAs currently encounter a patchwork of arbitrary state restrictions on services they can deliver to beneficiaries under state Medicaid programs. When such restrictions unnecessarily limit PA practice, patients suffer due to longer wait times and fewer care options. The removal of such restrictions would bolster the availability of care options for specific services and in underserved communities, promoting more timely access to care.

² Association of American Medical Colleges (AAMC). 2021. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Retrieved from <https://www.aamc.org/media/54681/download>

³ Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physician Assistants, at <https://www.bls.gov/ooh/healthcare/physician-assistants.htm> (visited June 12, 2023).

Equitable Access to Care for Medicaid Beneficiaries

In the proposed rules, CMS notes that differences in the ability of beneficiaries to access care providers results in disparities in access to care generally. Specifically, the rule states, “As a general matter, disparities in access to care related to demographic factors such as race, ethnicity, language, or disability status are, in part, a function of the availability of the accessible providers who are willing to provide care and are competent in meeting the needs of populations in medically underserved communities.” AAPA concurs that the inability to obtain care from a qualified health professional is a contributing factor in health inequities.

In 2021, AAPA surveyed all 51 fee-for-service Medicaid agencies. The results confirmed variation in authorizations for PAs to provide certain services. While not the case in most states, some state Medicaid agencies restricted PAs from ordering DME, providing psychiatric services, ordering home health, or first assisting at surgery. Patients seeking such services in those states in which PAs have practice restrictions have fewer options for receiving care. Consequently, geographic inequities brought about by a patchwork of unduly restrictive coverage policies may be contributing to an inequitable landscape of access to care.

AAPA Recommendations to Bolster Timely, Equitable Access to Care for Medicaid Beneficiaries

AAPA supports CMS efforts to improve beneficiary access to Medicaid services. The causes of access deficiencies are multi-factorial, including transportation, language services, availability of telehealth, provider availability, and beneficiary unfamiliarity with care options, to name a few. Improving Medicaid beneficiary access to care will require an equally wide-ranging approach, with the support of various types of care providers. PAs are qualified and prepared to play an important role in bolstering timely and equitable access to care.

In the proposed rule, CMS suggests several strategies which states may consider to increase Medicaid beneficiary access to care. Some examples include, “Changing scope of practice laws to enable more providers to fill gaps in access or joining interstate compacts...” Others include, “Increasing payment rates to providers, improving outreach and problem resolution to providers, reducing barriers to provider credentialing and contracting, providing for improved or expanded use of telehealth, and improving the timeliness and accuracy of processes such as claim payment and prior authorization.”

While AAPA supports these suggestions, we propose CMS make these recommendations to states more explicit. As noted in these comments, PAs can help meet demand in both primary care and specialties.^{4,5}

⁴ Peters AL. The Changing Definition of a Primary Care Provider. *Ann Intern Med.* 2018 Dec 18;169(12):875-876. doi: 10.7326/M18-2941. Epub 2018 Nov 20. PMID: 30458467.

⁵ Smith JM. Physician assistants in psychiatry: Helping to meet America's mental health needs. *Current Psychiatry.* 2019;18(9):17-22.

In addition to directly meeting demand, PAs can help expand the capacity of a practice to provide care to more patients.⁶

CMS should encourage or incentivize all state Medicaid fee-for-service and managed care plans to implement policies that are fully inclusive of PAs, ensuring the availability of a greater number of health professionals able to provide needed services. This would increase the number of care options available to Medicaid beneficiaries and as a result aid in increasing access to such care.

In the proposed rule, CMS indicates that, in addition to its regulatory actions, it is also undertaking non-regulatory actions, such as the development of best practices toolkits. AAPA recommends that the agency utilize such toolkits to communicate PA-related best practices. We further suggest that such best practices be communicated directly to state policymakers, as well as to both fee-for-service Medicaid and Medicaid managed care plans. AAPA has included below a list of some of the best practices we propose CMS communicate in forthcoming best practices toolkits.

- Medicaid plans should enroll PAs as, at minimum, rendering providers and require that claims for services provided by PAs properly identify the PA as having provided the care.
- Medicaid plans should authorize PAs to practice to the top of their state law scope of practice and remove any existing restrictions which hinder PA-provided care.
- Medicaid plans should include PAs in provider directories to make beneficiaries aware of all available care options. – *Discussed further below.*
- States that reimburse for services provided by PAs at a lower rate than physicians should increase PA reimbursement to the physician rate to sustain the financial ability of PAs being able to continue to provide such care and increase rates of health professional participation in the program – *Discussed further below.*

Enhancing Access as a Result of Care Option Transparency: Accurate Provider Directories

AAPA supports efforts by CMS to increase accuracy and transparency in provider directories, including the methods outlined in the proposed rules that would require annual secret shopper surveys of managed care plan provider directories. The rules, as proposed, would bring much-needed consistency to the way these surveys are conducted. This type of consistency will hopefully lead to uniform identification and quick correction of inaccurate information.

It is vital that the information available to beneficiaries about their network of providers be timely and accurate so they can determine the best care options for them. Information on care availability is particularly important in

⁶ Dai M, Ingham RC, Peterson LE. Scope of Practice and Patient Panel Size of Family Physicians Who Work With Nurse Practitioners or Physician Assistants. *Fam Med.* 2019 Apr;51(4):311-318. doi: 10.22454/FamMed.2019.438954. PMID: 30973618.

rural or underserved areas, and for health plans with limited networks. In a time of worsening health professional shortages, greater clarity and accuracy about all available care options can improve access to care.

Accuracy is especially important to the PA profession, because so often, even when PAs are included in provider directories, there is a potential for the manner in which they are included to do little to improve beneficiary knowledge of available care options. Provider directories are typically designed so that a beneficiary is prompted to search for a potential provider based upon the specialty in which they practice. This is understandable as it is an intuitive method for a beneficiary to search for care options. For example, a beneficiary with a skin lesion would select “dermatology” as a search filter in a provider directory to find an appropriate health professional to address their medical concern. However, as is the case with the Medicare program, 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 under the generic category of “physician assistant” or “PA.” As such, a PA who practices in dermatology may not be identified in the directory as dermatology provider and thus not present as a care option in a beneficiary’s search. 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 than an available PA, 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 should be accomplished by authorizing PAs to self-select the specialty in which they currently practice.

Enhancing Access as a Result of Payment Transparency

AAPA supports CMS’s proposed revisions to the existing payment rate transparency requirements as outlined in the rule. In the proposed rule, CMS seeks to require all states to publish their fee-for-service Medicaid payment rates in a manner that is easily accessible by the public and broken down by geographical area, population type (pediatric and adult), and provider type, where applicable. The improved accessibility and granularity of the data to be made publicly available as outlined in the proposed rule allows for stakeholders at every level, from state Medicaid agencies down to individual practices, to more easily and accurately identify and correct potential outliers and inefficiencies in Medicaid payment models. Of particular interest is the effect of payment rates on the availability of care options and access to care.

AAPA is encouraged by CMS’s inclusion of provider specific payment rate disclosures even in states where the payment rate for PAs and/or NPs is statutorily set at a reduced percentage of the physician fee schedule. As CMS states in the proposed rule, the requirement that states identify variations in payment rate by provider type will allow CMS and other interested parties to better determine if access to care is sufficient and how changes to payment rates may influence or affect a provider and their ability to continue providing those services. CMS even suggests the possibility that lower rates of reimbursement for “non-physician” health professionals may lead to lower participation and affect access. AAPA concurs that this is a logical inference, and the matter deserves closer evaluation. This is particularly important in rural and underserved communities where PAs and NPs may be the

only provider types offering certain services in these areas. It is for these reasons that we believe it is imperative that the proposed requirements for comparative payment rate analysis include the separate identification of payment rates by population, geographical location, and provider type and that, should correlations be identified, CMS seek to rectify these access barriers.

Ensuring Sufficient Representation on Medicaid Advisory Committees

Each State Medicaid program is required by federal regulation to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical services for Medicaid beneficiaries. The proposed rule offers thoughtful changes to the manner in which Medicaid programs interact with both beneficiaries and health professionals that AAPA believes will enhance the mission and effectiveness of the delivery of Medicaid services.

AAPA agrees with the proposal to change the name of the MCAC to the Medicaid Advisory Committee (MAC). This title would more clearly illustrate the purpose and focus of the committee's activities.

In addition to members of consumer groups, patients and certain state officials, the MAC, similar to the current MCAC, would consist of "board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care." Because PAs and other non-MD/DO health professionals make up a substantial portion of the healthcare workforce that delivers care to Medicaid beneficiaries, it is imperative that those same health professionals be able to fully participate in the MAC to adequately bring the unique perspectives of their respective professions.

There is a clear need to better educate health professionals, beneficiaries, and other stakeholders about the existence of a Medicaid Advisory Committee and how the committee can contribute to improving the delivery of services to vulnerable patients. Efforts to publicize, promote and recruit interested parties to participate in the MAC should be a high priority for all state Medicaid programs. MACs should be encouraged to schedule meetings during times that fit into the busy schedules of health professionals and also accommodate the inclusion of patients. In addition, the use of audio-visual and audio-only technology should be available to allow health professionals and other stakeholders to participate in meetings remotely.

AAPA also supports the concept of the proposed addition of a Beneficiary Advisory Group (BAG) which would require states to form and support a group comprised of individuals with lived experience as Medicaid beneficiaries. The BAG members would provide direct feedback to the state Medicaid agency *and also* participate in the MAC meetings. The BAG would meet separately in advance of MAC meetings, allowing BAG members the opportunity to provide direct input to the state and help prepare for the MAC meeting.

AAPA understands that these proposed changes will place additional responsibilities on state Medicaid agencies. However, the potential for enhanced state Medicaid programs that are more responsive to beneficiary needs and improve access and care outcomes make the additional efforts well worth the investment.

Thank you for the opportunity to provide comments regarding access to care and equity for Medicaid beneficiaries. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at michael@aapa.org.

Sincerely,

A handwritten signature in black ink that reads "Lisa M. Gables". The signature is written in a cursive, flowing style.

Lisa M. Gables, CPA
Chief Executive Officer