



July 27, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

The American Academy of Physician Assistants (AAPA), on behalf of the more than 100,000 Physician Assistants (PAs) throughout the United States, appreciates the opportunity to provide comments on the Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability proposed rule. PAs currently provide care under Medicaid programs in all 50 states and the District of Columbia. As the number of Medicaid beneficiaries continues to grow, and states continue to trend toward putting an increasing number of Medicaid beneficiaries under managed care plans, the rules governing such plans are becoming more important to the patient care experience. It is within that context that we draw your attention to our comments surrounding CMS' planned modifications to the Medicaid Managed Care (MMC) policy. For your convenience, we have divided our comments according to stated goals of the proposed rule.

Transparency

AAPA applauds program integrity efforts of the proposed rule which seek to increase the transparency of MMC plans. One way in which the proposed rule encourages increased transparency is through a requirement that states screen and enroll all network providers. However, the rule leaves open the possibility that such enrollment could be only for the

purposes of ordering and referring, as this is how many Medicaid Fee for Service (FFS) plans have interpreted a similar requirement. This limited interpretation of enrollment falls short of the full potential of the rule to create transparency.

AAPA strongly recommends that CMS provide clarification indicating that, for those health professionals who deliver primary care and other medical services, the purpose of enrollment in MMC plans goes beyond ordering and referring. MMC plans should be required to enroll professionals such as PAs so that PA-provided services on a claim can be tracked based upon who rendered the service helping to increase transparency and promote accountability. Such a requirement does not change PA scope of practice, nor duplicate costs or services, and payment would continue to be made to the employer.

The increased transparency and accountability that result from services being attributed to the actual provider of care also benefits patients. Quality improvements in care delivery will be the likely outcome when the care provided by each provider is monitored and appropriate feedback is received. In addition, patients should be able to find their health professional in the Medicaid program's provider directory. When PAs are not enrolled and recognized the ability of patients to choose them as a health professional is diminished.

Currently, thirty-six state Medicaid programs authorize PAs to use their own NPI when submitting claims, having recognized the significant benefits to this interpretation of enrollment. This number is expected to continue to grow. This increased transparency from acknowledgement of PAs on claims will also support another major provision of the proposed rule, namely the Implementation of state monitoring standards.

State Monitoring Standards

AAPA welcomes discussion on the need to collect data to improve performance, as well as the intention to publicly report and make changes based on the data collected. We believe that oversight is an important method to ensure quality. However, AAPA also believes that for data to be most useful, it must also be complete. While we applaud CMS' intention to

direct *what* activities are monitored, AAPA is concerned that not enough attention is being paid to *who* is monitored.

As noted above, when PAs are hidden providers, the integrity of any data collected is compromised, as *who* is actually performing the service is not captured for examination on a micro or macro level. Hidden provider billing practices deliver regulators and legislators inaccurate information about providers of healthcare services, which can lead to an inefficient allocation of taxpayer resources associated with workforce planning. As the physician shortage increases, data on workforce considerations such as knowing if a sufficient number of healthcare professionals are available in a region, and what the makeup of that body of workers is, would be useful data to provide insight into, and make policy decisions regarding, geographic and network adequacy.

Network Adequacy

AAPA supports robust provider networks in insurance plans to promote patient access to care options. If patients are not able to seek timely access to needed care, they run the risk of exacerbating their medical conditions. This may ultimately lead to higher treatment costs for individual patients and the healthcare system. Consequently, AAPA favors broad provider inclusion. However, sometimes the problem is not intentionally exclusionary practices, but incomplete information.

The proposed rule balances twin goals of standardization and flexibility by permitting states to determine the details of their network adequacy standards, while requiring that they measure by time and distance, and providing complementary elements for consideration such as expected enrollment numbers, the number of providers accepting Medicaid patients, geography, and language proficiency. AAPA is pleased there will also be an external quality review to verify such adequacy standards are being met. However, reviews and conclusions of network adequacy, both internally and externally, will rely on a foundation of accurate and representative data.

AAPA strongly encourages that healthcare reporting and billing systems identify medical and surgical services provided by PAs. This inclusion will greatly help inform state and federal workforce projections. Without data on who is performing what services, an incomplete picture compromises a state's ability to detect and adjust resources to fix network adequacy issues. For example, in a rural environment when a PA's services are billed under the physician, data may suggest that only one physician may work in an area, which could lead to the assumption of an under-served population, or lead to the assumption that one physician is capable of handling much more than they are able to without the work of providers like PAs. Either erroneous conclusion may lead to a reduction in resources to such an area that are used to support multiple providers. Improper resource allocations could then influence hiring practices, decreasing access to patient care options, and affecting the quality of care received by patients.

Standardization

In the proposed rule, CMS offers many modifications with the intention of increasing standardization across programs and the health sector. In addition to the MLR provision discussed later, one example of such a proposed modification is the purported appeals and grievance processes that seek standardization with Marketplace QHPs and Medicare Advantage. Another example is the proposed initial assessment of each enrollees needs under MMC plans, which seeks to mirror the Medicare programs initial preventive visit.

AAPA applauds attempts at reasonable cross-program standardization. Such efforts help to reduce confusion among beneficiaries, especially those who may move between programs such as Medicare and Medicaid or are dually eligible for both programs. In that spirit, AAPA has identified two additional opportunities for standardization:

- The Affordable Care Act (ACA) makes explicit mention of the importance of PAs to the provision of primary care, even defining them as primary care providers (PCPs). In order to standardize definitions, PAs should be given official status as PCPs in MMC plans. PAs

are deemed PCPs in some states, but other states have not formally given that status to PAs. For those states that require enrollees in MMC plans to be assigned to a PCP yet don't define PAs as PCPs, the ability of PAs to fully treat and care for patients is diminished. Defining PAs as PCPs in Medicaid programs would maximize PA utilization and increase access to care.

- In order to further standardize MMC with Medicare, CMS should require that PAs be enrolled for the purpose of indicating the actual rendering provider on claims. Such a requirement both in MMC and Medicaid FFS plans would ensure the same reporting of information and promote comparable data collection with Medicare. This standardization would send a strong message that those programs to which public funding is provided are achieving a high level of transparency and accountability to ensure appropriate spending.

Consumer-friendly Provisions

AAPA would like to commend CMS for the following efforts to improve consumer interactions with MMC.

- The Medical Loss Ratio (MLR), and its use in setting future rates, will help to encourage sufficient investment be made in care provided directly to patients. Instituting this MLR also stands to increase standardization, as this effort is similar to the one established by the ACA for commercial plans and Medicare.
- Coverage supports, such as the proposed beneficiary support system, will help provide a resource through personal assistance to quell frustrations and confusion. This may be especially valuable in helping alert consumers to plan options during the proposed 14 day trial period. Additionally, coverage protections, such as the rule's provision to continue providing benefits during an appeal, will help ensure that needed care is not halted over a potentially legitimate grievance. This may be particularly important for those patients receiving MLTSS that require continuous care provision.

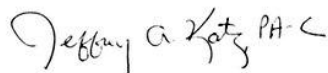
- Capitation payments to MMC plans for adult enrollees spending less than fifteen days in an Institution for Mental Disease will help expand needed coverage for this vulnerable population group. As this policy change stands to mitigate a prior gap in mental health coverage.

Conclusion

AAPA believes appropriate modifications to existing and proposed MMC policies can improve patient experience through improved quality, reduced confusion, and better access to care for patients. CMS has clearly laid out the goals of increasing transparency, collecting accurate data, ensuring robust provider networks, enhancing quality of care, standardizing practices, and promoting consumer-friendly policies. The agency can move a step closer to achieving those goals by assuring that PAs are fully included as health professionals within MMC and authorizing PAs to deliver care to the full extent of their education and expertise.

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

Respectfully,



Jeffrey A Katz, PA-C, DFAAPA
President and Chair of the Board