September 2, 2014

The Honorable Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244–1850

Dear Administrator Tavenner:

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 Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 as published in the July 11, 2014, *Federal Register*.

Physician Assistants (PAs) are committed to increasing access to quality healthcare services for all individuals and we seek to work in partnership with the Department of Health and Human Services (HHS) and CMS in both the development and advancement of policies that help achieve that goal. It is within that context that we draw your attention to the following issues.

Sustainable Growth Rate (SGR)

AAPA urges CMS to work with Congress to develop a long-term solution to the flawed sustainable growth rate formula in order to provide financial stability to the Medicare payment system.

An ongoing concern regarding Medicare payments, and consequently, Medicare beneficiary access to care in 2015 and beyond is the physician fee schedule conversion factor which is estimated to decrease payments by 20.9 percent on April 1, 2015, based on assumptions contained in a March 5, 2014 letter that CMS submitted to the Medicare Payment Advisory Commission, unless Congress acts. The impact on patients and healthcare professionals such as PAs, physicians and others would be catastrophic. Payment reductions of that magnitude, due to a flawed sustainable growth rate formula (SGR), will cripple access to care for millions of Medicare beneficiaries and devastate the financial viability of many practices. Admittedly, CMS does not control the SGR formula upon which the conversion factor is predicated and can't unilaterally mitigate the proposed reductions in reimbursement. However, it is imperative that the agency continue to work closely with Congress, the Administration, and the healthcare community to find a rational, long-term solution to the potential of substantial current and future payment fluctuations in Medicare payments.

Elimination of the Post-Operative Surgical Global Period

AAPA supports the concept of increased transparency in knowing which health professional provides care to Medicare beneficiaries, but urges CMS to be aware of the potential for unintended consequences if the post-operative surgical global period is eliminated.

AAPA understands the conceptual framework behind the CMS proposal to eliminate all 10- and 90-day global payments in 2017 and 2018, respectively. Historically for surgical reimbursement, Medicare pays

the surgeon a lump sum, also known as a global payment, covering the pre-operative history and physical, the intra-operative surgical procedure, and the post-operative care for a period of either 10 or 90 days depending on the particular surgical procedure. CMS is questioning the extent to which a surgeon or a qualified member of the surgeon's team is actually performing the post-operative work for which they have been paid through the current global payment process. CMS also questions whether payment should be made for a pre-assumed number of post-operative visits (which the current system does) as opposed to paying for the actual number of visits required by the surgical patient.

CMS now proposes to make one reduced payment to the surgeon to cover only those services delivered on the day of surgery. Payments for any post-operative visit(s) would be made separately to the healthcare professional that performs the post-operative evaluation and management service(s).

This proposal represents a radical change in payment methodology that will have serious ramifications on surgical practices. As such, CMS should proceed with caution and assure maximum transparency to avoid unintended, negative consequences. While AAPA believes that the identification of, and payment to, the health professional that actually performs the post-operative services could improve payment accuracy and fairness, we are also sensitive to the financial impact such a policy would have on both patients, surgical practices, and those who first assist at surgery.

In thinking about surgical patients, at present they receive post-operative visits with no additional charges as those visits are "included" in the global payment. If the CMS proposal is adopted, these same patients who seek post-operative care might be subject to deductibles and/or co-pays each time they receive a post-operative visit. Depending on the rules of the patient's health plan/insurance coverage and the number of post-operative visits needed, irrespective of who provides that care, patients could be subject to hundreds of dollars of additional expenses that they are not required to pay under the current system. That burden would be especially severe on patients at the lower end of the economic scale. Likewise, patients who are sicker or who have more complications could be forced to pay more money out of pocket as they would typically need more medical visits than those patients with fewer complications.

Equally concerning is the possibility that patients, in order to save money, would not access post-operative care services in a timely manner. The result could be medical complications, such as wound infections, which go untreated until a more acute intervention or a hospital re-admission was necessary, impairing the patient quality of life and costing the system more money.

This proposed policy change is not specifically aimed at altering the reimbursement for first assisting at surgery. However, reimbursement for first assisting is paid as a percentage of the global surgical fee. If the surgical fee is reduced, then those PAs and physicians who first assist would receive a reduced payment for their services despite the fact that their professional work and responsibilities has not changed. If this proposal is adopted, CMS should increase the Medicare percentage paid for assisting at surgery to assure that there is no loss in payment for these vital services.

Chronic Care Management

AAPA supports the CMS proposal to establish a policy to pay for chronic care management (CCM) services for Medicare beneficiaries with multiple chronic conditions.

AAPA appreciates the fact that CMS 1) understands that PAs, physicians and certain other healthcare professionals provide medically necessary services to Medicare beneficiaries for which there is no payment, and 2) remains committed to developing payment policy for chronic care management services. The current policy proposal builds upon concepts that were finalized in the calendar year 2014 final Physician fee Schedule rule. CMS proposes to authorize payment for non-face-to-face chronic care management (CCM) services if beneficiaries have two or more significant chronic conditions. The proposed payment of $41.92 can be billed no more frequently than once per month per qualified patient and requires at least 20 minutes of service every 30 days in order to bill the service.

We encourage the agency to review the payment amount to assure that it adequately values the professional services that will be provided by PAs, physicians and other professionals. It is important that the payment be an appropriate financial incentive that encourages health professionals to deliver CCM services which we believe will reduce costs to the overall healthcare system by keeping patients healthier and out of expensive, acute care settings.

In addition, CMS should review and reconsider some of the practice requirements necessary to bill CCM services. The ability for a practice to address a patient's acute chronic care needs 24-hours a day, 7-days per week is a very high standard. Requiring the use of electronic health record (EHR) technology that is certified to the most recent version of certification criteria as adopted by the Secretary of the Department of Health and Human Services may disqualify practices from billing for CCM services despite the fact that those practices have the ability to fully coordinate patient care with an EHR system that might not be the most current version according to HHS standards.

If CMS wants health professionals to utilize CCM codes, the barriers to entry should be reasonable while at the same time assuring high quality patient care coordination.

Expanded Coverage of Telehealth Services

AAPA supports the proposed expansion of covered telehealth services which would add 7 CPT codes to the existing list of approved Medicare telehealth services.

PAs are among the healthcare professionals authorized by Medicare to furnish telehealth services through an approved telecommunications system. The increased availability of telehealth services will improve beneficiary access to medical care, especially in rural and underserved communities. AAPA supports the CMS proposal to expand the use of telehealth by adding the following seven codes to the list of covered telehealth services:

- Psychotherapy services: current procedural technology (CPT) codes 90845 (psychoanalysis); 90846 (family psychotherapy (without the patient present)) and 90847 (family psychotherapy (conjoint psychotherapy) (with patient present))
- Prolonged services in the office: CPT codes 99354 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient evaluation and management service)) and 99355 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service))
- Annual wellness visits: Healthcare Common Procedure Coding System (HCPCS) codes G0438 (annual wellness visit; includes a personalized prevention plan of service, initial visit) and G0439 (annual wellness visit, includes a personalized prevention plan of service, subsequent visit)

Removal of Employment Requirements for Services Furnished ''Incident to'' Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits

AAPA fully supports the CMS proposal to eliminate the employment requirement for services provided "incident to" in Rural Health Clinics and Federally Qualified Health Centers.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) by design make healthcare services more accessible to individuals in rural and underserved communities. Because these practices often operate on thin financial margins, AAPA applauds CMS for providing increased staffing flexibility by proposing to remove the requirement that services furnished "incident to" a RHC or FQHC visit must be provided by a W-2 employee of the RHC or FQHC. Eliminating the need for a W-2 employment

relationship would allow nurses, medical assistants, and other auxiliary personnel the ability to furnish "incident to" services under contractual arrangements (i.e., independent contractor relationship) in RHCs and FQHCs.

AAPA continues to be supportive of the CMS policy change, as detailed in the May 2, 2014 final rule, *Medicare Program; Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics*, which allow RHCs and FQHCs to contract with PAs and nurse practitioners (NPs), if at least one PA or NP is a W-2 employee of the practice. The previous rule, which required that all PAs and NPs who delivered care at RHCs and FQHCs be W-2 employees, was both financially and administratively burdensome. This policy change will provide RHCs and FQHCs with improved staffing options that are cost-effective and reasonable based upon the individual and unique needs of each practice.

AAPA appreciates the agency's consideration of our comments and looks forward to working with CMS to ensure the best possible care for all Medicare beneficiaries. If you have any questions about 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,

John McGinnity, MS, PA-C, DFAAPA
President