American Academy of PAs

September 6, 2022

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 159,000 PAs (physician assistants/associates) throughout the United States, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) 2023 Physician Fee Schedule proposed rule. PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies in the proposed rule. As such, we seek to work in partnership with CMS to advance policies that would increase access to high quality care for all Medicare beneficiaries. It is within this context that we draw your attention to our comments.

Delayed Definition of "Substantive Portion" Under Split (or Shared) Visits

Historical Definition of Split (or Shared) Visit Billing

A split (or shared) visit refers to an E/M service that is performed "split" or "shared" by both a physician and a PA or nurse practitioner (NP) in a facility setting and billable by the physician at the physician fee rate. This

billing provision allows the combined services of both professionals to be billed under the physician's name and national provider identifier (NPI), with reimbursement at 100% of the Physician Fee Schedule if certain criteria are met. These criteria include:

- The PA and physician work for the same group/employer
- The PA and physician provide the service on the same calendar day
- Either the PA or physician must have a face-to-face encounter with the patient
- The physician must sign and date the medical record
- The physician must perform a "substantive portion" of the service

Prior to 2022, CMS defined a substantive portion as, "all or some portion of the history, exam or medical decision making key components of an E/M service."

CMS's Proposed Modifications to the Definition of Substantive Portion in the 2022 Fee Schedule Proposed Rule

In CMS's 2022 Physician Fee Schedule final rule, the agency modified the description of "substantive portion," defined differently in the years 2022 and 2023 and beyond. For the year 2022, CMS defines "substantive portion" for non-time-based services, as one of the key components (history, exam, or medical decision making (MDM)) in its entirety or more than half the total time spent on the service. For time-based services, such as critical care and discharge management, "substantive portion" would be met only if the physician performed more than half the total time spent on the service. For the years 2023 and beyond, CMS intended to modify the definition to be only more than half the total time spent on the service.

CMS asserts that it modified the definition of "substantive portion" to provide greater transparency and more accurate attribution of services as to who was providing split (or shared) visit services. AAPA shares these principles and agrees that the provider performing the substantive portion of the visit should be identified as the rendering provider of the service. However,
requiring a physician to spend and document more than 50% of the time with a patient is a significant change from current practices and will be an administrative burden. This burden may be more significant in hospital and facility settings where visits may be interrupted by other necessary services or procedures and time may be difficult to monitor.

CMS's Proposed Delay to the 2023 Definition of Substantive Portion in the 2023 Fee Schedule Proposed Rule

In the 2023 Physician Fee Schedule proposed rule, CMS partially acknowledges the significant concerns expressed by various stakeholders with its transition timeline. The agency proposes to delay for one year (until 2024) the definition of "substantive portion" as only based on time. Consequently, in 2023, instead of "substantive portion" being defined solely as a physician performing more than half the total time of the service, the definition can be met using 2022's standards of either the history, exam, MDM or spending more than half the time. CMS's delay is intended to provide an additional year for health professionals to "get accustomed to new changes and adopt their workflow in practice."

While AAPA certainly appreciates CMS's acknowledgement that the previous timeline to transition to a definition of "substantive portion" based solely on time was not practical (due to the requirements for drastically different methods of documentation), we are concerned that CMS's solution to these concerns is merely to delay use of the new definition for a year. AAPA continues to believe that the transition to determining whether a "substantive portion" has been met based solely on who performed more than half the time spent on the service has inherent flaws. However, maintenance of the current option for a substantive portion to be based on history or examination will no longer be possible with the pending changes to CPT coding and documentation. Consequently, AAPA proposes that CMS instead make permanent a policy of allowing either MDM or more than half the time spent on a patient's care as the two choices in determining whether a substantive portion has been met. We believe this concept, in addition to other recommendations CMS receives in response to this proposed rule, merit review from a multi-stakeholder group that could develop a more widely accepted definition that meets both transparency goals and minimizes burden concerns.

Meanwhile, if CMS is indeed committed to furthering the transparency of who is providing split (or shared) visit services, AAPA recommends that CMS require, in addition to a modifier indicating that care was provided under split (or shared) visit billing, that the name and NPI of the PA or NP participating in a split (or shared) visit be included on the claim. This is a step that could be taken now irrespective of a final decision by CMS regarding the appropriate definition of "substantive portion."

AAPA proposes that CMS make permanent the policy of allowing either MDM or more than half the time spent on a patient's care as the two choices in determining whether a substantive portion has been met. All recommendations CMS receives in response to this proposed rule should be reviewed by a multi-stakeholder group that includes PAs, NPs, physicians, etc. to properly balance concerns of transparency and burden. In addition, AAPA strongly recommends that CMS require that the name and NPI of the PA or NP participating in a split (or shared) visit be included on the claim, as this will provide the greatest transparency.

Request for Information: Medicare Potentially Underutilized Services

Contained within the 2023 Physician Fee Schedule proposed rule, CMS is soliciting feedback regarding ways to increase usage of high value services that are potentially being underutilized by Medicare beneficiaries. The agency is looking to identify specific barriers to access services that promote health and well-being and decrease spending in the healthcare system by reducing the need for more expensive care interventions.

CMS provides a list 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. 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. While no one policy can address each of these contributing

factors, AAPA believes that PAs are able to help ameliorate limitations on access to high value, underutilized services.

CMS is correct when it states in the proposed rule that obstacles to Medicare beneficiaries accessing such services exacerbates health disparities and reduces equity of care. Underserved populations suffer disproportionately due to access impediments. AAPA believes that reducing barriers to access high value potentially underutilized care has the potential to make a meaningful difference in reducing health disparities.

CMS has indicated that it is open to a wide-range of solutions to increase Medicare beneficiary access to such services, including examining conditions of payment and payment rates, beneficiary and provider education, new educational and marketing strategies, operational flexibilities, data sharing, and more. Consequently, AAPA has identified the following solutions to increase access to such services.

Authorize PAs and NPs to Order Medical Nutrition Therapy

In listing examples of high value, potentially underutilized services, CMS links to a webpage detailing Medicare Preventive Services.[1] Among those preventive services listed is Medical Nutrition Therapy (MNT). PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. Currently, however, only physicians are authorized to order MNT service. Language in the US Code, section 42 U.S.C. 1395x (vv)(1) reads as follows: "The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1))." This physician-only requirement results in administrative burden and delay in care for patients in need of these services, as patients must wait for a physician order. To increase access to preventive services, which CMS identifies in the RFI as an example of high value, underutilized services, AAPA requests that CMS support Congress adding "or a PA (as defined in subsection (aa)(5))" after (r)(1), which would authorize PAs to order Medical Nutrition Therapy, noted on the agency's website as a Medicare Preventive Service.

AAPA requests that CMS support Congress modifying 42 U.S.C. 1395x (vv)(1) to add "or a PA (as defined in subsection (aa)(5))" after "(r)(1)," which would authorize PAs to order Medical Nutrition Therapy.

Remove Restrictions on Care for Patients at Inpatient Rehabilitation Facilities

In the RFI, CMS identifies rehabilitation services as an example of high value, underutilized services. Currently, federal regulatory language (Code of Federal Regulations (CFR) 412.622(a)) regarding care in

[1] https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

Inpatient Rehabilitation Facilities (IRFs) is overly physician-centric, preventing other qualified health professionals such as PAs and NPs from meeting patient demand. For example, §412.622(a)(3)(iv) identifies the need to conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality and to modify the course of treatment as necessary. However, language contained in this section also requires that for the first week, a physician must do all three, and in each subsequent week, a non-physician health professional such as a PA or NP may only do one of the three visits per week. A different section, CFR §412.622(a)(4)(ii), requires a rehabilitation physician to develop a plan of care for a patient within four days of admission.

To address concerns of regulatory burdens in IRFs and ensure an adequate healthcare workforce for IRFs, CMS had previously expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs to fulfill many of the medical responsibilities previously assigned only to rehabilitation physicians. AAPA supported CMS's proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place. Unfortunately, CMS did not ultimately choose to provide the flexibility it initially proposed. AAPA requests that CMS reconsider. CMS should authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law. PAs have the appropriate training to ensure that IRF patients will continue to receive high-quality care when services are provided by PAs. CMS shows its agreement in its authorization for PAs to provide one of the three weekly required visits. Restricting PAs to only one service when the needs of an IRF may require more is an arbitrary restriction that may prevent access to high value, underutilized rehabilitation services. Granting an expanded authorization in this setting would not impose a requirement on IRFs, but rather give rehabilitation facilities maximum flexibility by providing them with the option to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation work force that provides patients with timely access to care. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients.

AAPA requests that CMS authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law.

Authorize PAs and NPs to Order Therapeutic Shoes

PAs and NPs are authorized to order durable medical equipment. The exclusion of therapeutic shoes for patients with diabetes is a rare exception to this authority. The RFI lists multiple examples of care for patients with diabetes as illustrations of potentially underutilized services. PAs and NPs commonly manage the care of diabetic patients. Currently, however, only a physician is authorized to certify the need for, and order, diabetic shoes. Language in the US Code, section 42 U.S.C. 1395x (s)(12) reads as follows: "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if— (A) the physician who is managing the

individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition." These requirements result in additional physician visits of a PA's or NP's diabetic patient who needs diabetic shoes, so that Medicare's requirements for the physician certification and order can be fulfilled. The change in health professional seeing a patient may cause additional access burdens or decrease patient satisfaction with the care experience. AAPA requests that CMS support Congress changing 42 U.S.C. 1395x (s)(12), subsections (A) and (C), to authorize PAs and NPs to certify the need for, and order, diabetic shoes. This will improve access to care and eliminate unnecessary physician visits and the cost associated with those additional visits.

AAPA requests that CMS support Congress changing 42 U.S.C. 1395x (s)(12), subsections (A) and (C), to authorize PAs and NPs to certify the need for, and order, diabetic shoes.

Authorize PAs to Perform Colonoscopies

AAPA approves of CMS proposals under the 2023 Physician Fee Schedule proposed rule that seek to expand coverage for colorectal cancer screenings. To do this, CMS proposes to reduce the minimum age payment limitation from 50 to 45 years of age for those tests with this limitation, as well as to cover as preventive (eliminating beneficiary cost sharing) certain follow-on screening colonoscopies after positive results from an initial screening. AAPA believes CMS should further increase access to colorectal cancer screening procedures by authorizing PAs to perform colonoscopies and eliminate current policy that payment for colonoscopies only be made when performed by a doctor of medicine or osteopathy.[2] No such limitation on the type of provider is included in the Social Security Act[3] and PAs have demonstrated the competency to perform colonoscopies, including biopsies when medically necessary, comparable to gastroenterologists in technical performance and quality metrics. Specifically, a study[4] demonstrated that there were no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies, and that "this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies."

The phased elimination of coinsurance for colonoscopies, while laudable, will likely lead to increased demand for trained and competent endoscopists. In addition, it has been estimated that initiating screening colonoscopies at age 45 rather than 50 years will increase demand for colonoscopies 22% and add 21 million people to the current pool of 94 million eligible persons.[5] The lowering and eventual removal of patient

[2] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf
[3] https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[4] https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx
[5] https://www.cghjournal.org/article/S1542-3565(20)30917-4/fulltext

coinsurance along with an increased demand from patients eligible for the procedure will place a serious strain on the availability of colonoscopy services. The increased demand for colonoscopies will likely have a disproportionately negative impact on rural populations obtaining access to this important preventive service. This lack of access would be counterproductive to CMS's goal of increased health equity. Consequently, AAPA recommends that CMS authorize PAs to perform colonoscopies.

AAPA requests that CMS authorize PAs to perform colonoscopies and eliminate current policy that payment for colonoscopies only be made when performed by a doctor of medicine or osteopathy.

Authorize Non-Physician Health Professionals to Interpret Electrocardiograms

CMS's policy regarding interpretation of electrocardiograms (EKGs) indicates that, "Coverage includes the review and interpretation of EKGs only by a physician."[6] The interpretation of EKGs is consistent with PA training, education and scope of practice. Rhythm interpretation is included in the Physician Assistant National Recertifying Examination (PANRE).[7] PAs deliver a wide range of professional services and there should not be unnecessary and unfounded barriers to the care delivery process. AAPA recommends that CMS modify the physician-centric language in its policy to authorize PAs and NPs to provide the professional interpretation for EKGs.

AAPA requests that CMS authorize PAs and NPs to provide the professional interpretation for EKGs.

Remove Restrictions Preventing Hospice-eligible Beneficiaries from Receiving Care

Not all high value, cost-effective services are curative. Hospice care is also underutilized.[8] This can lead to a prolonged patient usage of expensive and ineffective care. The causes of postponement in electing hospice care are multiple and may include the difficulty of a provider concluding a patient's prognosis is terminal and the difficulty in people confronting and accepting mortality. With so many factors delaying the use of hospice care, unnecessary policy barriers are only additive in harm. This vulnerable population should also not be required to face access delays once undergoing hospice care. Consequently, AAPA recommends CMS support Congress' removal of the prohibition of health professionals like PAs and NPs from certifying terminal illness, as well as the statutory exclusion of PAs as able to perform a face-to-face encounter prior to recertification of hospice. AAPA also recommends the removal of the regulatory restriction on PAs who work in a hospice and are not the attending physician from ordering medications for hospice patients.

AAPA requests that CMS support Congress' removal of the prohibition of health professionals like PAs from certifying terminal illness, as well as the statutory exclusion of PAs as able to perform a face-to-

[6] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r26ncd.pdf
[7] https://www.nccpa.net/wp-content/uploads/2021/05/CoreBlueprint-ContentCategory.pdf
[8] https://pubmed.ncbi.nlm.nih.gov/30142388/

face encounter prior to recertification of hospice. AAPA also requests that CMS remove the regulatory restriction on hospice-employed PAs ordering medications for hospice patients.

Promote Medicaid and Private Payer Alignment with Medicare Policies

For many Medicare beneficiaries, the Medicare program is not the only payer with whom they have coverage. Some Medicare beneficiaries may have Medicare coverage through a private payer, either due to enrollment in Medicare Advantage or because some beneficiaries under traditional Medicare may retain supplemental coverage through Medigap. Some Medicare beneficiaries are dually eligible for both Medicare and Medicaid (a population the RFI acknowledges is more likely to experience challenges in accessing healthcare services). Although Medicare may be the primary payer of dual eligible beneficiaries, a claim may often then be sent to the secondary payer, Medicaid, for additional coverage. If a Medicaid program does not enroll PAs or authorize them to perform a service, the agency may decline to provide additional monetary coverage. Consequently, it is in the best interest of Medicare beneficiaries if there is consistency in coverage policies across such payers. Private payers or Medicaid programs that do not enroll PAs or restrict PAs from providing a service Medicare authorizes them to perform risk leading to gaps in coverage and potentially increased costs and confusion for vulnerable populations. Consequently, AAPA recommends that Medicare encourage other payers to examine restrictive coverage policies that are inconsistent with Medicare policy.

AAPA requests that CMS urge payers to increase standardization of coverage policies with the Medicare program.

Authorize PAs to Supervise or Prescribe Cardiac, Intensive Cardiac, Pulmonary Rehab Services Prior to 2024

Studies have shown that Medicare patient outcomes are improved when they have access to cardiac and/or pulmonary rehabilitation services. Currently, only physicians are authorized to supervise and prescribe Medicare beneficiaries for cardiac and/or pulmonary rehabilitation services. When a physician is not available, the beneficiary does not have access to these important services. Supervising these services (establishing an exercise program, counseling, education, outcomes assessment, etc.) is within the scope of practice and level of expertise of appropriately trained PAs. Legislation passed Congress in 2018 to authorize qualified providers, including PAs and NPs, to supervise cardiac and pulmonary rehab services beginning in 2024. Currently there exists bipartisan legislation to move the implementation from 2024 to 2022, a critical change needed, especially in rural and underserved areas, with the increased demand for CR/PR services as the nation continues to fight COVID-19. Medicare has also interpreted "physician prescribed" exercise to mean that a patient must have a referral or order that is signed or co-signed by a physician.[9] AAPA and other stakeholders believe that a referral/order to cardiac and pulmonary rehabilitation is different than a physician-prescribed exercise plan and is an additional barrier to Medicare patients receiving these services.

[9] https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=270

AAPA requests that CMS urge Congress to pass the introduced bipartisan legislation that would move up the implementation date to authorize PAs to supervise and prescribe cardiac, intensive cardiac and pulmonary rehabilitation programs. AAPA also requests that CMS change its interpretation of physician-prescribed exercise and immediately allow PAs to refer eligible Medicare beneficiaries to these rehabilitation services.

Direct Supervision by Real-time, Audio/Video Technology Should Not be Made Permanent

Direct supervision is the level of supervision Medicare requires for "incident to" billing, some diagnostic tests, and certain other services. Direct supervision requires the supervising health professional to be immediately available (in-person, but not in the same room) to the professional delivering care. During the public health emergency (PHE), CMS indicated through IFC 1744[10] that direct supervision requirements could be met by the supervising clinician being available via audio/visual (real-time, interactive) communication. This flexibility was granted to minimize the transmission of COVID-19, meet the increased needs of patients, facilitate the utilization of telehealth, and mitigate the risk of patients not receiving timely medical care during a pandemic. CMS has elected to not move forward with making the temporary exception permanent. However, the agency is still seeking feedback for further consideration on the matter.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 PHE. We recognized that this flexibility was necessary to minimize exposure to COVID-19 and reduce detrimental impacts of the pandemic on the timely provision of care. However, at the same time we were concerned about the impact of such a policy on transparency and data collection efforts, and on increased costs to the Medicare program.

AAPA continues to have significant concerns regarding "incident to" billing for services provided by PAs/NPs and the transparency complications that come with it. As you are aware, "incident to" is a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to us is "incident to" billing pertaining to services performed by PAs and NPs that are attributed to a physician. Due to the manner in which services billed "incident to" are reported through Medicare's claims process, a substantial percentage of medical services delivered to Medicare beneficiaries by PAs and NPs may be attributed to physicians with whom they work. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services delivered by PAs and NPs. Accurate data collection and appropriate analysis of workforce utilization is lost. This lack of transparency has a negative impact on patients, health policy researchers, the Medicare program, and PAs/NPs.

One of the key issues in ensuring that healthcare is consumer-centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB)

[10] https://www.cms.gov/files/document/covid-final-ifc.pdf

notice after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of the visit. "Incident to" billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the MSN/EOB notice. When PA services are billed "incident to," the MSN/EOB lists the service as having been performed by a physician who was not seen by the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Physician Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals with an assessment of the professional's overall quality of care based on a Medicare computed performance score. When services performed by PAs are hidden due to "incident to" billing, not only is Medicare unable to determine PA quality scores, but these scores may not appear on the Physician Compare site if the health professional does not exceed the low-volume threshold because of a limited number of services being attributed to them. In addition, if PAs have all their services billed under "incident to," those PAs may not appear on the Physician Compare website. PAs not being identified on Physician Compare, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a healthcare provider.

With a substantial number of services provided by PAs and NPs attributed to physicians in "incident to" billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research performed using such data is similarly biased by a lack of attribution to the PA or NP who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distort the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies. Under "incident to" billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care, and resource use allocation.

The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and NPs in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and NPs was billed "incident to," and identified many of the adverse consequences of "incident to" billing stemming from compromised data quality.[11] Similarly, in CMS's recent 2019 Physician Fee Schedule final rule, the agency acknowledged that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services "incident to" a physician when furnished by a PA or NP.[12] The absence of data attributed to PAs and NPs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program, and threatens their ability to be listed along with other health professionals on performance measure websites, such as Physician Compare. Similar concern regarding the negative impact of "incident to" billing on the accuracy and validity

[11] https://www.medpac.gov/document-type/report/
[12] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf

of value-based programs has been echoed in a Health Affairs Blog in a January 8, 2018, posting.[13] While claims reimbursement is by no means the only measure of a health professional's value and productivity, it is an essential component. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, can influence the analysis of PA/NP healthcare contributions.

AAPA is concerned that CMS authorizing direct supervision requirements by audio/visual communication would only make it easier to use "incident to" billing, thereby leading to expanded use of the billing mechanism. This would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional.

Consequently, due to our ongoing concerns with "incident to" billing and its harm to transparency, AAPA instead suggests that direct supervision by audio/visual communication be authorized only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for these health professionals, such as registered nurses, medical assistants, and technicians, will allow for expanded patient access to care as it will increase flexibility in supervisory requirements for such professionals to perform their duties while not having an adverse impact on transparency. PAs and NPs are able to provide and bill for services under their own names instead of a physician's name, and at a lower cost of care (reimbursement rate) to the Medicare program. An extension of direct supervision by audio/visual communication for PAs and NPs would only serve to further impair data transparency through the potential proliferation of "incident to" billing.

AAPA strongly encourages that CMS not authorize direct supervision by real-time, audio/video technology for medical services performed by PAs and NPs.

Payment Accuracy for Global Surgical Packages

CMS is soliciting comments on how best to improve payment accuracy for global surgical packages. For ten years CMS has expressed concerns regarding the potential overvaluation of surgical packages, with particular emphasis on the number of post-op visits being performed by a surgeon or a PA/NP member of the surgeon's team. Working with RAND since 2017, CMS has made efforts to collect data from health professionals and practices on the number and intensity of post-op visits being performed within the global package. CMS believes that current RVUs for global surgical packages are inaccurate due to fewer post-op visits being provided as part of the surgical package and is looking for suggestions on how to revalue the actual work performed within the surgical package.

In its 2017 PFS final rule, CMS reduced its proposed reporting requirements from an overly burdensome mandate that required all health professionals to submit a series of G codes to demonstrate ten minute increments of post-operative global surgical E/M services to a more manageable method of data collection. Specifically, the new reporting requirements were aimed primarily at surgical practices in nine states that had ten or more health professionals. CMS asked for information on certain high-volume surgical services

[13] https://www.healthaffairs.org/do/10.1377/hblog20180103.135358/full/

and a Healthcare Common Procedure Coding System code became the method of reporting. In the 2019 PFS/QPP proposed rule, CMS explained it had not yet received a robust data-submission response.

Additional research and data collection activities by RAND, including an updated report published in 2021, confirms a need to revalue the number of post-operative visits performed by the surgical team as part of the global surgical package. AAPA understands and appreciates the goals of determining the appropriate value of services and levels of reimbursement for surgical services. While AAPA appreciates that CMS arrived at this conclusion after appropriately collecting evidence on the matter, we believe a discussion with affected stakeholders (e.g., PAs and other health professionals, patient groups, medical societies and associations, and payers) to revalue global surgical payments should be undertaken.

The agency must be cautious in making major policy changes without fully understanding the impact of those changes beyond the issue of accuracy in global surgical valuations. Certain policy decisions surrounding this issue could have immediate negative impacts on patients. For example, CMS could decide to change policy and eliminate post-operative visits from the global surgical , requiring patients to receive individual evaluation and management services for post-operative care. In this scenario, those post-operative visits that were formerly provided without any fees in the global bundle would now be subject to deductibles and/or co-payments for each visit. These new payments could be a financial burden to beneficiaries and cause them not to receive needed follow-up care following surgery.

AAPA also stresses that any future modifications to the current global surgical payment for 90-day global procedures should not be done in a way that inadvertently penalizes health professionals who serve as a surgical assistant. A decision to separate the post-operative payment from the global surgical bundle could create an unfair lowering of reimbursement for surgical assisting services, which are paid at a percentage of the total global surgical package reimbursement amount. This potential substantial reimbursement reduction for assisting at surgery could occur even though the professional work and intensity of the surgical assistant services have not changed. AAPA encourages CMS to avoid financially penalizing those professionals who assist at surgery due to the "law of unintended consequences" as this discussion and valuation process moves forward.

AAPA encourages CMS to engage in a discussion with affected stakeholders (e.g., PAs and other health professionals, patient groups, medical societies and associations, and payers to revalue global surgical payments. AAPA also asks that CMS avoid financially penalizing professionals who serve as surgical assistants due to any future changes to the global surgical package valuation.

Modifications to Certain Evaluation and Management (E/M) Guidelines

In the 2023 Physician Fee Schedule proposed rule, CMS proposes to generally adopt the revised Current Procedural Terminology (CPT®) evaluation and management (E/M) Guidelines for Other E/M visits developed by the American Medical Association. The revised guidelines will align with Office or Other Outpatient E/M Guidelines and better reflect the current practice of medicine.

AAPA supports the proposal that the level of service for a patient visit be selected based on either the amount of time a health professional spent performing the visit or the level of medical decision making required for the visit. AAPA further supports CMS removing the history and physical examination components as required elements contributing to the level of service.

Although CMS proposes to mostly adopt the revised codes and changes in CPT code selection and documentation guidance, there are several significant discrepancies between the CPT guidelines and the policies CMS proposes in the 2023 Physician Fee Schedule proposed rule. CMS should align regulations in accordance with CPT guidance as is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Secretary of Health and Human Services (HHS) has previously adopted the *Current Procedural Terminology - Fourth Edition* (CPT-4) as a recognized code set under HIPAA. As such, the CPT-4 and other code sets are required to be used for claims processing by Medicare, Medicaid, and other health programs. Deviating from CPT-4 not only violates requirements established by HIPAA and HHS, but could create variations in coding and documentation between Federal and commercial payers. This will add to the already existing administrative and documentation burden practitioners face due to disparate policies among various payers.

For example, CMS proposes that for both initial and subsequent visits, when PAs and NPs work with physicians, the PAs (and NPs) should always be classified in a different specialty than the physician. This is directly contrary to general CPT-4 guidance in the *CPT 2022 Professional Edition*, which states, "When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialties as the physician." A similar discrepancy is found in policies for critical care billing. CMS indicates that a physician and a PA (or NP) are not classified as the same specialty, so the policy related to critical care furnished by practitioners in the same specialty and same group does not apply; disallowing a physician and PA (or NP) working in the same group and same specialty on the same calendar day from separately reporting 99291 and subsequent 99292(s) under their respective names and National Provider Identifier. Instead, CMS states that a physician and PA (or NP) providing critical care in the same group, and even practicing in the same specialty, can only bill 99291 and subsequent 99292s as a split (or shared) service under one billing practitioner, which is determined based on who provides the substantive portion of all critical care on a calendar day.

Another misalignment between CPT-4 and Medicare policy proposed in the 2023 Physician Fee Schedule rule relates to calculating critical care time needed to bill 99292(s). The agency indicates they intend to make a technical correction to Medicare billing policy for critical care services. Specifically, CMS intends to require *completion* of 30 minutes of critical care time to bill CPT code 99292. CPT-4 defines CPT code 99292 for critical care as "*up to* 30 minutes" of evaluation and management of the critically ill or critically injured patient of each beyond the first 74 minutes. CPT-4 indicates that CPT codes 99291 and 99292 can be billed at 75 minutes of critical care time, while CMS indicates the two codes would only be reportable after 104 minutes. Similar time discrepancies would be an issue for all additional 1-30 minutes of critical care time and billing.

For clarity, consistency, and compliance, AAPA urges CMS to align Medicare policy for initial and subsequent visits and critical care with CPT-4. CMS policy should classify PAs (and NPs) in the same specialty as the physician(s) with whom they work or collaborate for purposes of determining initial and subsequent services and concurrent critical care time.

AAPA supports the proposal that the level of service for a patient visit be selected based on either the amount of time a health professional spent performing the visit or the level of medical decision making required for the visit. AAPA further supports CMS removing the history and physical examination components as required elements contributing to the level of service. AAPA urges CMS to align Medicare policy for initial and subsequent visits and critical care with CPT-4. CMS policy should classify PAs (and NPs) in the same specialty as the physician(s) with whom they work or collaborate for purposes of determining initial and subsequent services and concurrent critical care time.

Ambulance Services

Physician certification is required for nonemergency, scheduled, repetitive ambulance services.[14] In the 2023 Physician Fee Schedule proposed rule, CMS is seeking to provide clarity on medical necessity and documentation requirements for these services. However, it stops short of addressing the physician-centric language, which may be causing access barriers or delays. This mode of transportation may be the only option available to patients receiving services like dialysis or wound care and who have a contraindication to other modes of transportation. An inability to receive a timely authorization for such transportation may contribute to necessary services being delayed or unused. Consequently**,** AAPA requests that CMS modify § 410.40(e)(2) to authorize PAs and NPs who care for those patients who require nonemergency, scheduled, repetitive ambulance care to be able to provide the required certifications to ensure these patients have access to needed services. As indicated in the proposed rule, CMS previously extended the ability of PAs and NPs to sign a certification statement for other types of ambulance transfer (for unscheduled, or scheduled but not repetitive).

Similar barriers exist in emergency ambulance transfers. In certain instances, patients are unable to access care most appropriate to their healthcare needs. Patients should be able to transfer to another care setting with minimal difficulty. However, if a patient requires an emergency transfer under EMTALA and a physician is present, the physician must certify the transfer. If a physician is not present, a PA may certify the transfer, but only after consultation with a physician who must subsequently co-sign the certification. Such requirements are antiquated and inefficient. PAs can authorize a transfer in most nonemergency situations and should be authorized to in emergency situations. Requiring a physician signature is administratively burdensome. When a physician is not present, the requirement for physician consultation, especially in areas with a deficient number of available physicians, may prolong the transfer process to a facility more equipped to meet a patient's immediate needs, thereby delaying access and potentially endangering the patient's

[14] https://www.palmettogba.com/palmetto/jmb.nsf/DID/8T4MAF7511

health and increasing care costs. In addition, the requirement for co-signature is then superfluous, as the determination to transfer a patient has already occurred and adds administrative burden. AAPA recommends that PAs should be able to certify the need for transfer under EMTALA without physician consultation and co-signature.

AAPA requests that CMS modify § 410.40(e)(2) to authorize PAs and NPs who care for patients who require nonemergency, scheduled, repetitive ambulance care to be able to provide the required certifications. In addition, AAPA recommends that CMS make the necessary modifications that would allow PAs to certify the need for transfer under EMTALA without physician consultation and co-signature.

Claim Submission for Initial/Subsequent Nursing Facility Visits Independent of an Initial Comprehensive Visit

In the 2023 Physician Fee Schedule proposed rule, CMS proposes to allow for an initial or subsequent nursing facility (NF) visit to be furnished and billed by an authorized practitioner (PA, physician, NP, or clinical nurse specialist as specified in § 483.30) regardless of whether the initial comprehensive assessment has been performed. AAPA supports this proposal as it allows for appropriate reimbursement even when the typical course of care (initial comprehensive assessment followed by subsequent visits) does not occur, as is sometimes necessary.

There are often clinical conditions/situations that require a visit from an authorized practitioner prior to the completion of the initial comprehensive assessment. For example, a patient could fall or develop a fever due to an infection that requires a separate medical visit which occurs prior to the performance of the NF comprehensive assessment. These are medically necessary services that should be reimbursed by Medicare when performed. Confusion may exist among health professionals and Medicare Administrative Contractors regarding billing and payment for an initial or subsequent NF service that occurs before completion of the comprehensive assessment. This often leads to unfair payment denials. CMS's proposed policy change will help bring clarity to appropriate billing protocols.

To further increase the availability of care in NFs, AAPA recommends that CMS authorize PAs and NPs to personally perform the initial comprehensive assessment. Under current policy, these comprehensive assessments may be delayed while waiting for a physician to perform the service. PAs and NPs are completely capable by education and expertise to personally perform the comprehensive assessment.

AAPA supports the CMS proposal to allow for an initial or subsequent NF visit to be furnished and billed prior to the performance of the initial comprehensive assessment. AAPA also recommends PAs and NPs be authorized to personally perform the initial comprehensive assessment.

Changes to the Medicare Shared Savings Program

In the 2023 Physician Fee Schedule proposed rule, CMS is proposing several significant changes to the Medicare Shared Savings Program (MSSP). The goal of these changes to the MSSP is to encourage greater participation in Accountable Care Organizations (ACOs). Some of the changes proposed include providing advanced payments to certain new or low-revenue ACOs that could help address social needs, giving smaller ACOs more time to transition to downside risk, creating a health equity adjustment for the performance category to reduce penalty to ACOs caring for an underserved population, and the adjustment of benchmarks. There were also changes made to reduce the administrative burdens of ACOs.

AAPA supports CMS's proposed policies that seek to encourage participation in ACOs. ACOs are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. However, AAPA encourages further changes to MSSP policies to simplify participation in an ACO.

PAs are listed by Medicare as one of three types of health professional groups who deliver primary care services. However, only patients who have had at least one visit by a physician are eligible to be assigned/attributed to an ACO.[15] Medicare beneficiaries treated solely by PAs and NPs cannot be automatically assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA is the only health professional in the community. Requiring that assignment be contingent on a physician encounter may prevent Medicare beneficiaries in these communities from accessing the coordinated care provided by ACOs.

Patients treated by an ACO physician are automatically attributed to the ACO through the claims process. That same process is not available to PAs and NPs. Patients must take the extra step of going online to select a PA (or NP) as their ACO provider in order to be assigned to an ACO. In previous rules, CMS acknowledged that the claims-based assignment methodology is the method by which the "vast majority of beneficiaries are assigned."[16] AAPA recommends that CMS support changing the statute to allow patient attribution to an ACO based on claims when a patient received their care exclusively from non-physician health professionals like PAs and NPs. Allowing primary care services furnished by PAs and NPs to count for purposes of ACO assignment will remove a barrier for patients to access coordinated care and encourage ACO formation by helping health care providers attain enough ACO beneficiaries to participate in the MSSP.

AAPA supports CMS's proposed policies that seek to encourage participation in ACOs. AAPA requests that CMS support changing the statute to allow patient attribution to an ACO based on claims when a patient has received their care exclusively from non-physician health professionals like PAs and NPs.

[15] https://www.law.cornell.edu/cfr/text/42/425.402
[16] https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success

Increased Flexibilities for Behavioral/Mental Health

In the 2023 Physician Fee Schedule proposed rule, CMS correctly identifies the public health emergency as exacerbating existing barriers to behavioral/mental care at a time of increasing demand. As a result, CMS identifies several proposals that seek to make it easier for Medicare beneficiaries to access needed behavioral/mental health services. The proposed changes include making an exception to the requirement for direct supervision of certain behavioral health professionals, such as licensed professional counselors and licensed marriage and family therapists, who have no separate statutory benefit category and thus are required to have all services billed "incident to," and under direct supervision of, a physician or other practitioner. If finalized, many behavioral health services would be allowed to be performed under the general supervision of a PA, physician, or NP. CMS provides estimates that together, the number of licensed professional counselors and marriage and family therapists may total nearly 200,000, and postulates that increased flexibility in services delivered by this group may ameliorate provider shortages. Another proposal of CMS is to create a General Behavioral Health Integration service personally performed by clinical psychologists and clinical social workers with services provided by these professionals serving as the focal point for care integration. AAPA approves of the proposed changes that seek to reduce barriers and thereby increase access to behavioral health care.

While AAPA appreciates these proposals made by CMS to increase access to behavioral/mental healthcare, we believe more can be done and that PAs can play an important role in increasing beneficiary access. PAs practice in psychiatry and provide behavioral health services across multiple specialties. With PAs demonstrating that they are qualified providers of behavioral/mental health services, further action by CMS on this issue, including the encouragement of private payers with whom the agency contracts to remove outdated barriers to PAs providing this care, can bolster the number of PAs practicing in relevant specialties to alleviate access concerns in a time when demand is increasing.

Worsening Shortages and Decreased Access

Mental and behavioral health, much like healthcare generally, is experiencing worsening physician shortages, compounding already existing access issues. Sixty percent of US counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health treatment and contributing to inadequate care and unsafe conditions.[17] A recent New York University study found that while demand for mental health services is increasing, patient access is decreasing.[18] Untreated

[17] Substance Abuse and Mental Health Services Administration. 2019. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[18] Heath, Sara. PatientEngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. Retrieved from https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows

mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.[19]

The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than needed to meet the demand for services.[20] 156 million people live in communities with limited access to mental healthcare services.[21] The National Council for Behavioral Health expects that, by 2025, there will be a deficit of 12% in the psychiatric workforce to sufficiently address patient needs.[22] An inadequate supply of providers of mental health services may lead to delays in diagnosis and care, rationing of resources, ineffective care, and increased negative consequences of mental illness and substance use.[23] These problems will be further magnified in rural and underserved areas.

Increased flexibilities of behavioral health professionals will have a positive impact in addressing such access issues. However, more may need to be done to encourage non-physician health professionals to fill some of the care gaps due to shortages in psychiatrists and increased demand. Qualified health professionals must be authorized to practice to the fullest extent of their license and training. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

PAs are Qualified to treat Behavioral/Mental Health conditions and improve access to behavioral mental health services. services

PAs are trained and qualified to treat mental and behavioral health conditions through their medical education, including extensive didactic instruction and clinical practice experience in psychiatry and other medical specialties, and have national certification, state licensure, and authority to prescribe controlled and non-controlled medications.[24] PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral health services. Based on their graduate medical education, PAs practicing in mental health and substance use treatment can expand access to necessary care. PA education includes thousands of hours of didactic and clinical practice experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan from pediatrics to geriatrics, providing a foundation to address the diverse medical needs of people with mental illness or substance use issues.[25]

---

[19] Mayo Clinic. 2019. Mental Illness. Retrieved from https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968#:~:text=Untreated%20mental%20illness%20can%20cause,Family%20conflicts

[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. Rockville, Maryland. Retrieved from https://www.hrsa.gov

[21] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[22] National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. Retrieved from https://www.thenationalcouncil.org

[23] Ibid

[24] American Academy of PAs. What is a PA? Retrieved from https://www.aapa.org/what-is-a-pa/

[25] Ibid

PAs perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans, and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists.[26] In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs, working with other members of the healthcare team, have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to that of physicians.[27] Authorizing PAs to deliver this high-quality care to patients can alleviate ongoing and worsening trends in access to behavioral and mental health services.

Consequently, PAs are qualified to help confront these trends. PAs work to ensure the best possible care and outcomes for patients in every specialty and setting, interacting with patients with mental and behavioral conditions in psychiatry, family medicine, internal medicine, emergency medicine, and other specialties.

The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics, with a projected 31% increase in PAs from 2018 to 2028.[28] This growth projection, along with PAs' qualifications, suggest that the increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

The number of PAs practicing in psychiatry, has remained low due to restrictions placed on PAs in this specialty by some commercial payers. However, the recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act,[29] CMS's inclusion of PAs as authorized providers in community mental health centers,[30] and the establishment of PAs as mental and behavioral health providers at the state level.

---

[26] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. *American Journal of Preventive Medicine.* 2018. Geographic variation in the supply of selected behavioral health providers. Retrieved from https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext.

[27] Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from https://www.medpac.gov

[28] U.S. Bureau of Labor and Statistics. 2020. Occupational outlook handbook: Physician assistants. Retrieved from https://bls.gov

[29] 21st Century Cures Act. Public Law No: 114-255 2016. Retrieved from https://www.congress.gov/bill/114th-congress/house-bill/34/text

[30] Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. Retrieved from https://www.law.cornell.edu/cfr/text/42/485.904

Additional Action CMS Can Take to Increase Access to Behavioral/Mental Health Care

While Medicare, many state Medicaid programs, and commercial payers cover behavioral and mental health services provided by PAs, some private payers, some of which interact with Medicare and its beneficiaries, do not. Private payers should authorize payment for all behavioral and mental health services provided by PAs that are performed in compliance with state law.

Private payers removing outdated policies that may act as barriers to behavior and mental healthcare will allow for greater utilization of the PAs that currently practice in behavioral health, as well as encourage a greater number of PAs to practice in psychiatry and related specialties. The increased demand for behavioral and mental health services requires the contribution of all qualified health professionals without outdated restrictions, that have not been demonstrated to be needed, constraining access to care. AAPA requests that CMS communicate to the many payers with whom the agency contracts that prohibitive policies by those organizations of PAs providing behavioral/mental health services should be eliminated to enhance access to quality care.

AAPA requests that CMS urge payers to eliminate prohibitive policies surrounding PAs providing behavioral/mental health services.

Extension of Certain Telehealth Flexibilities

The use of telehealth increased dramatically throughout the COVID-19 pandemic. Telehealth has demonstrated its ability to improve and extend patient access to care. Telehealth, even after the pandemic ends, will continue to be an essential modality of care, especially in rural and underserved communities and AAPA encourages the agency to create and maintain policies and regulations that foster the utilization of telehealth.

Specifically, AAPA supports CMS's proposal to continue coverage for services on the Medicare Telehealth Services List furnished during the period of 151 days after the end of the PHE, implementing provisions of the Consolidated Appropriations Act, with the originating site for the telehealth service being any site in the United States at which the beneficiary is located when the service is furnished, including the beneficiary's home. In addition, we ask that CMS work with Congress to permanently authorize a telehealth originating site of service to be any site where the beneficiary is located. A statutory change to the definition of originating site will ensure that patients with logistical, mobility, transportation and other challenges will continue to have access to appropriate and timely care. We also support a permanent change to current Medicare statutes to allow for telehealth services to be delivered in any geographic area.

While we understand that two-way, audio-video communications technology is the traditional Medicare standard for delivery of telehealth services, AAPA urges the agency to be aware of the potential challenges experienced by many Medicare beneficiaries regarding the use of audio-video technology. A lack of access to computers/smart phones, a lack of knowledge of how to utilize technology, poor quality or a lack of internet

availability all act as deterrents to beneficiaries using two-way, audio-video technology. For many beneficiaries, audio-only technology is the only practical way to access services via telehealth. CMS should be cautious about establishing or maintaining policies which hinder beneficiary access to care.

AAPA asks CMS to work with Congress to permanently establish policies authorizing a telehealth: 1) originating site of service to be any site where the beneficiary is located; 2) service to be delivered in any geographic area; and 3) service to be delivered via audio-only technology if the beneficiary indicates they are unable or unwilling to use two-way, audio-visual technology.

Proposal Related to Diagnostic Tests Without a Physician Order

In the CY 1997 PFS, CMS established at § 410.32(a) that all diagnostic tests must be ordered by a physician who is treating a beneficiary. At the same time, CMS finalized a provision at § 410.32(c) (later redesignated to § 410.32(a)(2)) that PAs and other non-physician qualified health care professionals (QHPs) may be treated the same as physicians for purposes of § 410.32(a), indicating that a PA and other non-physician QHPs may order diagnostic tests for Medicare beneficiaries they are treating.

AAPA appreciates the authority under § 410.32(a)(2) for PAs to order diagnostic tests. However, this authority is listed as a sub-regulation to § 410.32(a) and, as such, has repeatedly caused people who do not read the full text of § 410.32(a) through § 410.32(a)(2) to erroneously interpret that only a physician may order diagnostic tests for Medicare beneficiaries. This has led to refusals to furnish diagnostic tests ordered by PAs, delays in care, and administrative burden.

AAPA requests CMS revise § 410.32(a) to read, in part, that "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician or qualified health care professional (e.g., PAs, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, and NPs) who is treating the beneficiary". This would eliminate the need for sub-regulation § 410.32(a)(2), which could be deleted.

AAPA also requests a technical correction to § 410.32(b)(2)(i) and § 410.32(b)(2)(iii) related to general and personal supervision.

In the interim final rule with comment period published on May 8, 2020, in the Federal Register titled "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" (the May 8th COVID-19 IFC) (85 FR 27550, 27555 through 27556, 27620), CMS revised § 410.32(b)(1) to allow for the duration of the PHE, PAs and certain other non-physician QHPs to supervise the performance of diagnostic tests. In the CY 2021 PFS final rule (85 FR 84590 through 84492, 85026), CMS further revised § 410.32(b)(1) to make the revisions made by the May 8th COVID-19 IFC permanent and to add certified registered nurse anesthetists to the list of non-physician QHPs permitted to supervise diagnostic tests.

While § 410.32(b)(1) and § 410.32(b)(1)(ii) were appropriately updated, § 410.32(b)(2)(i) and § 410.32(b)(2)(iii) were not revised to include PAs and other non-physician QHPs. As noted in the 2023 Outpatient Prospective Payment System, of the three levels of defined supervision (§ 410.32(b)(2)(i), § 410.32(b)(2)(ii), § 410.32(b)(2)(iii)), only the definition for direct supervision was modified to indicate that a "supervising practitioner" other than a physician can provide the required supervision. The definitions for general and personal supervision continue to refer only to a physician. However, CMS notes that although the definitions of general and personal supervision do not specify that a "supervising practitioner" could furnish these levels of supervision, the revisions to the "basic rule" governing supervision of diagnostic tests at § 410.32(b)(1) provide the authority for PAs and other non-physician QHPs to provide all three levels of supervision. Despite PAs and other non-physician QHPs having the authority to provide general and personal supervision based on the "basic rule", the outdated definitions § 410.32(b)(2)(i) and § 410.32(b)(2)(iii) have caused confusion and an incorrect interpretation that PAs and other non-QHPs cannot provide general or personal supervision to the extent authorized by state law, when in fact they can. CMS has proposed in the Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule that, for purposes of clarity, § 410.27 and § 410.28 be revised to correct this technical error.

For additional clarity and purposes of consistency, as well as to eliminate inefficiencies or delays in care that a misinterpretation of CMS's intended policy could cause, AAPA requests that CMS revise § 410.32(b)(2)(i) and § 410.32(b)(2)(iii) to include "or other supervising practitioner".

AAPA requests CMS revise § 410.32(a) to read, in part, that "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician or qualified health care professional (e.g., PAs, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, and NPs) who is treating the beneficiary". AAPA also requests that CMS revise § 410.32(b)(2)(i) and § 410.32(b)(2)(iii) to include "or other supervising practitioner".

Mobile Components Operated by Opioid Treatment Programs

In the 2023 Physician Fee Schedule proposed rule, CMS is proposing to modify § 410.67(d)(4)(ii) to authorize Opioid Treatment Programs (OTPs) to bill Medicare for services furnished by mobile units. The agency expects that this authorization will expand access to medications for treatments for Opioid Use Disorders (OUDs) by more readily reaching underserved populations and areas. Consequently, CMS will apply a geographic locality adjustment so that OUD treatment services provided by mobile units will be treated as if furnished at the physical location of the OTP on file with the Substance Abuse and Mental Health Services Administration and the US Drug Enforcement Administration.

AAPA supports CMS efforts to expand coverage and simplify the process for the reimbursement of these services. Beyond the authorization for OTPs to bill for mobile OUD treatment services, CMS's proposed changes simplify the process by providing clarity regarding how to treat patients who are seen both by a mobile unit and at the OTP physical location. We believe mobile units can increase access to needed services, bringing care directly to patients who may have mobility issues, lack transportation, live in a rural setting, or

who are homeless. We encourage CMS to find additional opportunities to support mobile care as part of its overarching efforts to decrease disparities and promote health equity. Creative and proactive efforts to bring care to patients where they are should not face unnecessary restrictions.

AAPA supports CMS efforts to expand coverage and simplify reimbursement of services provided by mobile units. AAPA requests that CMS find additional opportunities to support mobile care.

Proposed Reduction in the 2023 Conversion Factor

Health professionals who participate in the Medicare program are facing a potential significant payment cut to Physician Fee Schedule payment rates beginning January 1, 2023. The upward valuation adjustment for inpatient E/M services, a budget neutrality statute, and the expiration of a one-year 3% increase passed by Congress last December are responsible for the projected conversion factor (CF) decrease. The Medicare CF, which in dollar terms is scheduled to decrease by $1.53 from $34.61 to $33.08, jeopardizes the financial stability of both health professionals and medical practices that serve Medicare beneficiaries.

This proposed across-the-board cut to Medicare payments do not recognize the rising inflation in medical practice costs and the COVID-related challenges practices continue to face. Health professionals across the country have been asked to do more over the past two and a half years and they have been incredibly resilient in meeting the needs of patients. Imposing a cut of this magnitude is short-sighted, will have a negative impact on health professionals, and risks diminishing the ability for Medicare patients to obtain adequate access to care.

AAPA encourages CMS to work with Congress to eliminate the proposed payment cuts for 2023, provide a positive payment update for 2023 that acknowledges the increased cost of delivering care, and work to devise a more fair, consistent, and sustainable fee schedule payment system going forward.

The Quality Payment Program (QPP)

In the 2023 Physician Fee Schedule proposed rule, CMS again demonstrates that it wants to make minimal changes to the current workings of the traditional Merit-based Incentive Payment System (MIPS) program under the QPP. AAPA supports the decision to make minimal changes to MIPS ahead of the implementation of the MIPS Value Pathways (MVPs). We believe keeping such metrics as performance weights, performance thresholds, and payment rates at previously established levels provides some semblance of consistency while health professionals and employers evaluate the manner and process by which they will participate in MVPs.

The one exception to CMS keeping levels consistent with the previous year is the increase in the data completeness threshold. AAPA understands the need for CMS to raise submission standards as it continues the progression toward meaningful value-based reimbursement. We encourage CMS to continue to be mindful of unexpected burdens, especially those incurred by smaller practices, in the final years of traditional MIPS and through the transition to MIPS Value Pathways.

Under the 2023 Physician Fee Schedule proposed rule, CMS still provided additional details on the QPP that merit further comment. For your convenience we have divided our comments on this issue by subtopic.

Removal of Promoting Interoperability Revaluation for PAs

AAPA is pleased that CMS has chosen to remove its policy, found at § 414.1380(c)(2)(i)(A)(4)(ii), of automatically revaluing the MIPS Promoting Interoperability score for PAs, NPs, CRNAs, and CNS' to zero. Over the years AAPA had expressed concern with the motivations for this revaluation, which was rooted in the agency's uncertainty as to whether PAs and NPs have the appropriate knowledge and familiarity with electronic health records (EHRs) to participate. Consequently, CMS had made participation optional with an automatic reassignment of this category's weight to one of the other three MIPS categories if no data was submitted.

While AAPA understands the intention of CMS was to provide flexibility, the notion that PAs and NPs did not have sufficient experience with Certified Electronic Health Record Technology (CEHRT) systems was unfounded. PAs in most practice settings have been using EHR systems for years, and sometimes lead an EHR system implementation, optimization, and management. Consequently, we are pleased that CMS has disposed of this artificial distinction and that PAs will be held to the same standard as physicians. For those PAs and NPs that still believe they are unable to adequately participate in this category, hardship exemptions are available, as they are for any type of participating health professional or group.

AAPA also believes CMS can take further steps in supporting the ability of PAs and NPs to report on CEHRT usage. AAPA recommends that CMS encourage medical practices, hospitals and other health care entities/stakeholders to develop and implement electronic medical record systems that authorize PAs and NPs to utilize EHR systems with the same functionality granted to physicians. If health professionals, such as PAs, are prevented from fully accessing and utilizing CEHRT systems, the ability of the health professional to sufficiently provide care that is efficient, safe, and coordinated, as well as the ability to report on their use of CEHRT, may be jeopardized.

AAPA supports CMS's proposal to remove its policy, found at § 414.1380(c)(2)(i)(A)(4)(ii), of automatically revaluing the MIPS Promoting Interoperability score for PAs, NPs, CRNAs, and CNS' to zero. In addition, AAPA recommends that CMS encourage medical practices, hospitals and other healthcare entities/stakeholders to develop and implement electronic medical record systems that authorize PAs and NPs to utilize EHR systems with the same functionality granted to physicians.

Additions to Physician Compare

In the 2023 Physician Fee Schedule proposed rule, CMS expresses interest in making additions to its Physician Compare website that may better aid patients in determining the most appropriate care for them.

These changes include a telehealth indicator of whether a health professional furnishes telehealth services, as well as utilization data that indicates conditions treated or procedures performed.

AAPA supports the concept of providing additional information to patients that would help them identify the care that is best for them. We believe these additions, in principle, could help address health equity by increasing access for underserved populations that would benefit from telehealth care, as well as potentially increase care efficiency by identifying to prospective patients the type of care typically performed by individual health professionals. However, we are concerned that data used by CMS may be insufficient to accurately capture conditions treated or procedures performed. As a result of billing mechanisms like "incident to," many services provided by health professionals such as PAs and NPs are attributed to a physician. Consequently, if a PA or NP reports individually through MIPS, the information on their Physician Compare webpage may be an incomplete representation of the types of conditions treated and care provided. This could give patients an inaccurate understanding of care options available to them.

To remedy this, in the absence of the elimination of "incident to" billing, AAPA requests that CMS seek regulatory solutions regarding how to properly identify PAs and NPs on claims submitted "incident to" and ensure they are able to extrapolate such information when making information available about the types of services a health professional performs. CMS may also wish to put a disclaimer (in addition to the proposed disclaimer, of which we approve, that services listed only apply to those provided to Medicare patients) on any public information of services rendered that examples provided are only a sampling and that the health professional may provide additional services than what is presented. However, such a qualifier would not allow certain health professionals to be accurately queried when a patient uses the system to search for care options based on types of services provided.

AAPA requests that CMS identify a method to properly identify PAs and NPs on claims submitted "incident to" and ensure the ability to extrapolate such information when making information available about the types of services a health professional performs. In addition, AAPA requests that CMS include a disclaimer on any public information of services rendered that examples provided are only a sampling and that the health professional may provide additional services than what is presented.

Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities

In the 2023 Physician Fee Schedule proposed rule, CMS indicates it is considering allowing CME accreditation organizations to serve as third party intermediaries that may submit data for health professionals seeking to identify their improvement activities under MIPS. As third party intermediaries, like QCDRs, qualified registries, Health IT vendors, and other CMS-approved vendors, the national CME accreditation entities would be able to submit information on CME completion in lieu of a health professional needing to make an attestation.

AAPA conditionally supports creating a new type of third party intermediary that would allow CME accreditation entities to submit for the MIPS Improvement Activities category. While having a CME accreditation organization report information does not absolve MIPS participants from submitting additional information needed to meet Improvement Activities category completion, doing so may help reduce burden to the health professional in an already laborious reporting process. However, AAPA is interested as to whether CMS envisions there being an additional cost burden passed on to the health professional by the CME accreditation organization for submission of information, and whether such costs, if they exist, justify the reduced burden. AAPA would also be interested in knowing the number of MVPs it anticipates will utilize this metric. If, after analysis regarding the potential costs versus the potential reduction in burden to health professionals, CMS chooses to proceed with allowing certain national CME accreditation organization to act as third party intermediaries for data submission under the Improvement Activities category, AAPA suggests that CMS provide sufficient training, resources, and information on enrollment and submission to prepare these intermediaries. AAPA also suggests that CMS require that any accreditation entity recognized as a third party intermediary report the completion of CME and the maintenance of certification for the improvement activities performance category for all MIPS-eligible clinicians. Reporting should be done for all clinicians completing the activity (and not just for the profession of the accrediting organization) and upon the "completion" of the activity and not upon the "awarding" of credit (since some accrediting organizations do not "award" credit to all MIPS-eligible clinicians).

Finally, AAPA cautions that CMS must extend this authority to all national accreditation entities that cover MIPS Eligible Clinicians,[31] so that any burden reduction is shared equally among the various types of participating health professionals.

AAPA conditionally supports creating a new type of third party intermediary that would allow CME accreditation entities to submit for the MIPS Improvement Activities category. AAPA requests that CMS provide sufficient training, resources, and information on enrollment and submission to prepare these intermediaries. AAPA also suggests that CMS require that any accreditation entity recognized as a third party intermediary report the completion of CME and the maintenance of certification for the improvement activities performance category for all MIPS-eligible clinicians. Finally, AAPA requests that CMS extend the authority to report for MIPS Improvement Activities to all national accreditation entities that cover MIPS Eligible Clinicians.

Digital Quality Measurement

In the 2023 Physician Fee Schedule proposed rule, CMS seeks further feedback on the agency's efforts to advance Digital Quality Measurement and the use of Fast Healthcare Interoperability Resources (FHIR) and again anticipates specific requirements regarding data submission standards will be released in future rulemaking. Specifically, CMS is interested in feedback regarding a refined definition of digital quality measures, the transition to digital quality measurement, data standardization, and information exchange.

[31] https://qpp.cms.gov/mips/how-eligibility-is-determined#mips-eligible-clinician-types

AAPA had previously made comments to the 2022 Hospital Outpatient proposed rule, which had contained a similar request for information. We wish to reiterate some of our previous comments here.

Digital Quality Measures use health information that can be captured and transmitted across interoperable systems and from various data sources, such as EHRs, medical devices, claims data, case management systems, patient portals, wearables, and more. The aggregation of this data from multiple sources would allow for a more holistic perspective of a patient's well-being and the type of care received by reducing data fragmentation. AAPA approves of the ability to extract data from more sources, however, there must be assurance that there are standards for accuracy and usability of new data sources.

The transition to Digital Quality Measurement relies not only on interoperability but also on increased standardization of data. CMS is proposing to collect all clinical EHR data required for quality measures via FHIR-based application program interfaces (APIs), allowing drastically different software used at different care locations to communicate and submit data similarly. FHIR is a standards framework that seeks to unify measure structure and reporting by establishing a common language and process for all health information technology. CMS expects the FHIR framework to provide consistency as it seeks to align standards across federal and state agencies, as well as private commercial payers. AAPA approves of CMS aspirations to increase standardization of measures and processes across public and private payers. Such consistency would simplify the process and reduce reporting burden on healthcare professionals, as well as allow for greater comparability across programs.

AAPA concurs with CMS's goals of an increase in relevant data sources, reduced complexity in quality measurement, and enhanced ease of data submission. AAPA agrees that health professionals, such as PAs, would benefit from increased standardization and interoperability. If collection of data for reporting can be incorporated as an automated background system process occurring during a health professional's course of providing care, extraction and analysis of this data would not have to be a separate time-intensive process that could be prone to human error. We also see value in CMS's intent of rapid feedback through access to near real-time quality measure scores, as it would allow for prompt adjustments to be made to care and practice patterns, and processes. Increased ease of data transmission may also benefit health professionals by supporting their ability to enhance care coordination and support more precise clinical decisions.

However, AAPA would like CMS to consider certain issues when developing or modifying measure requirements. The three concerns listed below are essential for CMS to address if it is committed to enhancing the holistic nature of data collection, promoting increased coordination of care, increasing the integrity of data, and ensuring increased usefulness of feedback on quality.

First, health information technology that will collect data for Digital Quality Measurement must be accessible and useable by all health professionals who provide medical care to patients. AAPA recommends that CMS encourage medical practices, hospitals and other health care entities/stakeholders to develop and implement electronic medical record systems that authorize PAs and NPs to utilize EHR systems with the same functionality granted to physicians. If health professionals, such as PAs, are prevented from fully accessing and utilizing CEHRT systems, data collected will be imprecise.

Second, any newly established or modified measures should not be phrased in a way that might exclude health professionals. Capturing the contribution of health professionals, like PAs and NPs, through appropriately worded measures will allow CMS to reach its goal of enhanced comparability of care quality.

Third, digital measures and the corresponding feedback must be accurately attributed to the health professional who rendered the service. This will maximize the relevance of data capture and analysis by ensuring that feedback used to adjust and improve clinical practice be returned to the professional who delivered the care. To do this, AAPA requests that CMS address the complications of inaccurate data collection caused by the "incident to" and split (or shared) billing methods, which attribute services personally performed by PAs and NPs to a physician.

When the transition occurs, the agency should ensure there is sufficient time to meet required technical milestones and provide adequate widespread instruction on new requirements to affected stakeholders. AAPA recommends that CMS, in addition to soliciting feedback on the details of the implementation, also consult various stakeholders on the feasibility of designated timelines. CMS must be sure that interoperability is a well-established standard at the point of implementation or assessments of quality will continue to be incomplete due to missing, unavailable, or misattributed data. AAPA cautions that there may be entities that cannot financially or logistically make necessary transitions. Educational and other assistance may be necessary to improve the capacity for such entities to meet Digital Quality Measurement requirements and standards.

AAPA requests that CMS urge medical practices, hospitals and other healthcare entities/stakeholders to develop and implement electronic medical record systems that authorize PAs and NPs to utilize EHR systems with the same functionality granted to physicians. AAPA also requests that CMS ensure any newly established or modified measures should not be phrased in a way that might exclude health professionals. In addition, AAPA requests that CMS address the complications of inaccurate data collection caused by the "incident to" and split (or shared) billing methods, by ensuring services are accurately attributed to the health professional who rendered the service. Finally, AAPA recommends that CMS, in addition to soliciting feedback on the details of the implementation, also consult various stakeholders on the feasibility of designated timelines.

Qualified Practitioner (QP) Determination at the Eligible Clinician Level

Currently, under the QPP's Advanced Alternative Payment Models (APMs), most determinations of Qualified Participants (QPs) are made at the APM entity level. CMS is considering changing this to instead require that QP determinations be made only at the eligible clinician level. To become a QP, certain thresholds must be met regarding the percentage of Medicare Part B payments received, or the percentage of patients seen, through an Advanced APM entity during a performance period. CMS believes that currently, in order to qualify, prospective APM entities are excluding specialists and other health professionals that individually do not meet those thresholds because they provide care elsewhere, and thus may decrease the average of the whole entity and lead to the exclusion of other health professionals. CMS reasons that the exclusion of these

health professionals would work against the intended goals of APMs to encourage different types of health professionals to work together to manage and coordinate care. Instead, CMS proposes to determine QP eligibility for each health professional individually at the NPI level and allow only individuals to make QP status (preventing potentially unwarranted payment bonuses for practitioners under the APM entity that do not meet QP requirements, as well as discouraging APM entities from excluding health professionals whose care may be important to meeting patient-centered care goals).

While AAPA appreciates these concerns, this policy change will have unintended effects on certain other health professionals, such as those who are required by an employer to utilize "incident to" billing. PAs and NPs whose services are entirely, largely, or in part attributed to a physician with whom they work may individually fail to meet QP thresholds, preventing them from receiving associated financial benefits and burden reductions. This is likely to be exacerbated by the statutory increase in QP thresholds scheduled to occur this year. AAPA recommends that CMS implement a method to determine when a PA provides a service under "incident to" and to use such data in consideration for meeting the QP thresholds.

AAPA requests that CMS develop a method to determine when a PA provides a service under "incident to," by either eliminating this billing mechanism or requiring the reporting of the NPI of the health professional who provided the service, and to use such data in consideration for meeting the QP thresholds.

MIPS Value Pathways (MVPs)

To move away from a system in which health professionals and groups choose what to report from a large set of measures that are often not comparable, CMS has developed a method of reporting in which a health professional or group selects a pathway, structured around a specialty or particular medical condition, that best aligns with the type of care typically provided. These pathways, or MVPs, would be built on a base of claims-based population health and care coordination measures and would be supplemented with measures that reflect activities one would perform for the chosen specialty/medical condition. Measures reported under an MVP would be like those reported by other health professionals who have also chosen that same pathway, increasing comparability of clinical quality, outcome, and cost performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and allow for quicker administrative and clinical feedback provided to health professionals to improve care. CMS further believes these changes will help remove barriers to APM participation and accelerate the transition to value-based care.

In the 2023 Physician Fee Schedule proposed rule, CMS continues the process of implementing MVPs by proposing five additional pathways for voluntary reporting in 2023, in addition to the seven pathways proposed the previous year. AAPA appreciates CMS's proposal to post draft versions of MVP candidates on the QPP website for public feedback, as well as its plans to solicit ongoing feedback throughout the year and to hold annual public webinars regarding revisions to MVPs. We have long advocated for the need for increased transparency and stakeholder participation in the formulation and implementation of MVPs and

commend the agency's commitment to transparency in the process. However, AAPA recommends that, in order to encourage more health professionals to begin voluntary participation, the number of MVPs available be increased as quickly as possible, including MVPs that focus on issues that may appeal to large groups of providers.

AAPA continues to support CMS efforts to reduce complexity in the MIPS program and enhance comparability. We caution that CMS's efforts at comparability remain encumbered by billing provisions such as "incident to" that obscure the accurate attribution of services to the appropriate health professional. That is, scores representing an individual health professional's performance when some of their services have been attributed to another health professional are incomplete and inaccurate. While CMS is developing methods to improve data reporting under MIPS, AAPA requests that CMS take necessary steps to rectify the problem of data accuracy by addressing the complications of inaccurate data collection caused by the "incident to" billing method, which attributes services personally performed by PAs and NPs to a physician.

In the 2023 Physician Fee Schedule proposed rule, CMS also updates its policies regarding subgroup determination. Subgroup reporting is voluntary for CY 2023-2025 performance years, but multispecialty groups will be required to report as subgroups starting in 2026. In our comments to the 2022 Physician Fee Schedule proposed rule, AAPA expressed opposition to CMS determining specialty through PECOS. We noted how it would disadvantage PAs who are viewed by Medicare as practicing only in the specialty "physician assistant" and not the actual specialty in which they clinically practice. If PECOS is the determining factor of specialty in a single-specialty subgroup, PAs working in cardiology, for example, would be restricted from reporting with cardiologists in their office who provide similar care to comparable patients.

We are pleased that CMS has heard our concerns and proposed an alternative method. However, AAPA finds risk in CMS's proposed alternative to determine specialties through claims data. The identification of specialties through claims data could misalign a health professional due to artificial groupings determined by CMS, and by CMS collected data that may be incomplete (as a result of billing mechanisms such as "incident to") or inconclusive.

AAPA believes that subgroup composition should not be defined by specialty, but instead by the shared relevance of an MVP topic for all subgroup participants. AAPA could conceive subgroups that are made up of health professionals from more than one specialty if they are reporting to an MVP that is focused on a condition that requires cross-specialty cooperation. For example, a Valve Clinic may submit to an MVP focused on comprehensive valve care, and the group of practitioners could include an interventional cardiologist, cardiothoracic surgeon, cardiologist, and PA practicing in cardiology. Allowing varying compositions of subgroups and the resulting data may even allow for CMS comparison of the most effective composition of health professionals in providing beneficial outcomes. Much like in the selection of an MVP, health professionals should self-select themselves into appropriate subgroups. We believe that health professionals are incentivized to choose both the most appropriate subgroup and the most appropriate MVP for them since, if they do not, their ability to score well on specialty-specific measures will be compromised and would negatively affect their reimbursement. AAPA suggests that subgroups could attest to the similar focus of its participants during MVP registration.

In the 2023 Physician Fee Schedule proposed rule, CMS also proposes that individual health professionals, identified by the combination of their employer's TIN and their NPI, would be limited to participating in only one subgroup. This is the only restriction CMS is placing on subgroup composition and is being implemented because it is currently the only way to determine which subgroup a claim should be connected to. While we recognize this policy is being implemented due to a lack of a method to distinguish between which subgroup should be assigned a specific claim for scoring purposes, we encourage CMS to address these logistical issues as certain health professionals may work in an office in various subgroups depending on the practice's needs. Maintaining this limitation may inhibit a practice's flexibility to use health professionals, especially PAs who may work in different specialties to accommodate the needs of their patient population.

CMS also will apply the low-volume threshold to subgroups. AAPA finds this recommendation acceptable, increasing the likelihood of health professionals within a subgroup meeting the threshold and being able to participate in the MVP.

It is essential that CMS take the necessary steps to effectively implement MVPs. When CMS is developing its full array of MVPs, it must work with the provider community to identify potential gaps in MVP subject concentration so there are no health professionals who cannot appropriately report to any of the available MVPs. It will be imperative that CMS ensure there are a sufficient number and variety of MVPs to cover all participating health professionals. AAPA encourages the agency to specifically seek input from various types of affected health professionals when determining which specific specialties/conditions will be recognized by CMS as pathways. PAs should be included early in the process as they have unique perspectives and concerns regarding implementation details because of their practice in multiple specialties.

Health professionals like PAs and NPs also have interest in ensuring that newly developed measures are structured or phrased in a way that is inclusive. In addition, measures must be able to adequately capture various roles and responsibilities that may be filled by different health professionals on the care team. If CMS wishes to receive a comprehensive picture of activities performed under a specialty with which to construct their pathways, the various types of health professionals that deliver care and will be expected to report must be consulted. The more accurately CMS can capture the contribution of health professionals like PAs and NPs through appropriately worded measures, the more successful CMS's goal of enhanced comparability will be.

AAPA also believes that CMS recognizes the extent to which this will be another significant transition for providers. This is why CMS proposed to delay public reporting of data submitted through the MVPs. To further alleviate concerns regarding the transition to another reporting method, CMS must ensure that all relevant stakeholders are properly educated about the MVP choices, how to enroll, what is required for reporting, the potential monetary effects, and how to receive and act on feedback in a meaningful way. Efforts to educate those affected will also require adequate time for review, analysis, and a robust system to provide feedback. AAPA suggests educational efforts include examples of MVPs and their corresponding measure sets with a detailed description of how one would be rated on these measures, as well as clinical vignettes of various scenarios that vary by specialty and reporting method. CMS should use public meetings, webinars, and online resources to broaden awareness and expand the understanding of the MVP process.

AAPA supports the CMS proposal to post draft versions of MVP candidates on the QPP website for public feedback, as well as its plans to solicit ongoing feedback throughout the year and to hold annual public webinars regarding revisions to MVPs. AAPA requests that CMS increase the number of MVPs available as quickly as possible, including MVPs that focus on issues that may appeal to large groups of providers. AAPA encourages the agency to specifically seek input from various types of affected health professionals when determining which specific specialties/conditions will be recognized by CMS as pathways, as well as regarding the applicability of various measures to an MVP. AAPA also AAPA requests that CMS take necessary steps to rectify the problem of data accuracy by addressing the complications of inaccurate data collection caused by the "incident to" billing method. In addition, AAPA requests that CMS authorize subgroups to attest to the similar focus of its participants during MVP registration. Finally, AAPA suggests educational efforts include examples of MVPs and their corresponding measure sets with a detailed description of how one would be rated on these measures, as well as clinical vignettes of various scenarios that vary by specialty and reporting method.

Thank you for the opportunity to provide feedback on payment policies under the 2023 Physician Fee Schedule proposed rule. AAPA welcomes further discussion with CMS regarding these 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,

Jennifer M. Orozco, DMSc, PA-C, DFAAPA
President and Chair, Board of Directors