American Academy of Physician Associates

June 12, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information; Health Technology Ecosystem

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the nearly 190,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments on the Improving Technology to Benefit Patients request for information (RFI). AAPA appreciates CMS's commitment to improving beneficiary experience through increased use of, access to, and usefulness of technology.

AAPA believes that modern technology has increasingly removed barriers to care, as well as enabled patients to make more informed care decisions. Precision surgeries with less chance of human error, the detection of conditions through advanced diagnostic tests, more durable retention of medical information through EHRs, electronic methods of prescribing, and simplified processes for documentation and billing are just some of the positive recent technological developments that benefit patients. Other technologies that contain great benefits for patients, such as provider directories, interoperability, and patient portals continue to evolve and be implemented. AAPA supports CMS efforts to further empower patients through technology. However, for beneficiaries to realize the full benefits of these technologies, outdated and inefficient barriers to proper use must be removed. It is within this context that we draw your attention to our comments.

Technology to Improve Beneficiary Access to Their Information

Data Retrieval Through Provider Portals

Beneficiaries must be able to access their personal medical data. As such, beneficiaries benefit from the ability to quickly retrieve such information through accessible patient portals offered by health providers. Navigating portals to view this information should be intuitive and, when feasible, any medical information should be displayed in a form that is as easily understandable as possible. Should there be continued questions regarding personal medical information, the name and contact information for the health professionals who provided each service should be available.

Portability of personal medical information is also important. Beneficiaries have several reasons why their medical information may need to be accessible to new providers, from a medical emergency while traveling or moving out of a geographic location, to changes in which providers are covered by their insurance plan, or a desire to seek additional or new care options. As such, beneficiaries must be authorized to continue to access patient portals beyond the time in which they see a care provider and, in doing so, must continue to have the ability to access their personal medical information.

Interoperability and the Transmission of Personal Medical Information

The importance of portability of patient information also accentuates the need for interoperability, or the ability of electronic information systems to communicate. Should a beneficiary see a new care provider, the new care provider must be able to retrieve prior medical information from any providers that have previously treated the patient. Prior medical conditions and interventions, and other data from patient medical records, may be essential in providing appropriate care.

AAPA has long recognized the importance of interoperability in improving the functionality of patient health information and data. In the past, AAPA has communicated to CMS its support for increased interoperability between systems and has advocated for the agency to provide necessary educational, financial, and logistical support to ensure widespread adoption of steps that would encourage interoperability. As such, we support CMS's ongoing and future efforts to better capture the extent of successful adoption of interoperable systems.

CMS currently requires the existence of a Patient Access Application Programming Interface (API). APIs allow different software applications to communicate and facilitate the exchange of data between various entities. Patient Access APIs enable patients to retrieve their health information from providers and payers through a compatible health application. AAPA supports policies that provide increased patient access to personal healthcare

information. As such, in previous comments to the agency, we have supported broad requirements for APIs between patients, providers, and payers.

These APIs should allow patients to retrieve personal medical data from both providers and payers, as well as allow for care data to follow a patient should they choose to change providers or payers. These APIs would also be helpful to patients who have concurrent coverage with more than one payer or who receive care from multiple providers. We recommend, as has been proposed by CMS previously, establishing intervals in which data sharing between concurrent payers and providers must occur, if approved by a patient.

Technology to Improve Beneficiary Access to Information Regarding Care Options

Provider Directories

AAPA supports CMS's goal of assisting patients in making care decisions that are best for them through increased use of appropriate technology. One form this currently takes is through provider directories, used by beneficiaries to identify available care delivery options. However, CMS has recognized the inadequacy of provider directories as recently as its 2022 RFI[1], noting that provider directories in their current form often display inaccurate or redundant information and are frequently missing essential information that may be valuable to beneficiaries and patients. For provider directories to be most successful, information contained in them must be complete, accurate, and navigable.

Some provider directories omit information notifying beneficiaries of all available care options. For example, while not always the case, PAs are occasionally omitted from a payer's provider directory. As essential members of healthcare teams, PAs must be included explicitly in all public and private payer provider directories. However, even when PAs are included in provider directories, there is a potential for incomplete information to be made available that hinders beneficiary choice and access. Provider directories are typically designed so a beneficiary is prompted to search for a potential provider based on the specialty in which a provider practices. PAs are often not enrolled with payers in a particular specialty and, consequently, are not listed in many provider directories under the specialty in which they practice. Instead, PAs are often listed in provider directories under the generic category of "physician assistant" or "PA."

[1] Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Request for Information; National Directory of Healthcare Providers & Services. October 7, 2022. https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-ofhealthcare-providers-and-services

If a beneficiary is looking for care in dermatology, a PA who practices in dermatology may not be identified in the directory as a dermatology provider. The beneficiary may instead select a provider specifically listed under the category of dermatology but who might be located at a greater distance from the beneficiary and/or have substantially longer wait times, both of which create access issues for beneficiaries. To remedy this situation, PAs should be identified in provider directories under the specialty in which they practice and not placed into a generic "physician assistant" or "PA" category. This can be accomplished by authorizing PAs to report the specialty/specialties in which they practice to the payer.

One of the core principles of the PA profession is flexibility and the ability to change practice specialties. This flexibility is essential in helping to meet the changing healthcare needs of patients. Unlike physicians, who are typically board-certified in a particular specialty, PAs are nationally certified to practice in all medical and surgical specialties. The profession's comprehensive, generalist medical education, training, and preparation give PAs the capability and expertise to practice in different specialties and change specialties in response to the changing healthcare needs of patient populations. Maintaining this practice flexibility is especially important because of 1) challenges facing the healthcare workforce, including the current and growing shortage of physicians and the increasing problem of attrition of health professionals due to provider burnout and/or retirement; 2) the need to deliver increased access to care for patients in rural and underserved communities; and 3) the necessity to rapidly respond to future public health emergencies. Authorizing PAs to report their practice specialty to Medicare will improve provider directory transparency, inform beneficiaries of all available care options, and support the PA profession's continued ability to meet the evolving needs of the US healthcare delivery system.

The Importance of Accurate and Useful Data for Beneficiary Care Decisions

The harmful consequences of incomplete information can be seen not only in providers not appropriately being included in provider directories, but also in inadequate and misleading data. If patients do not have access to accurate data, they may not be able to make fully informed decisions about their care.

One way data can be misleading is through the process of attributing the services and outcomes of one health professional to another. Such improper attribution gives beneficiaries an, at best, incomplete, and at worst, deceptive, understanding of a health professional's capabilities, as captured by various quality ratings available to beneficiaries through public reporting websites such as Medicare's Care Compare. This is worrisome, as publicly facing quality scores, such as Medicare's STAR ratings, may be a valuable tool when a beneficiary chooses between multiple care options.

CMS has acknowledged, in previous technology-related rules, the importance of appropriate attribution of services to the health professional who provided them. AAPA concurs with CMS's assessment. Unfortunately, certain

current fee-for-service Medicare policies obscure the actual provider of care. “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 under the name of another health professional. Of particular interest to us is “incident to” billing of services performed by PAs attributed to a physician. PA services submitted under Medicare’s “incident to” billing provision and attributed to physicians skew assessments of provider care quality, creating inaccurate data on both PAs and physicians, and resulting in data that inhibits a beneficiary’s ability to make objective assessments. Consequently, AAPA requests that CMS work with Congress to address the complications of inaccurate data collection caused by “incident to” by ensuring services are accurately attributed to the health professional who rendered the service.

Similarly, some commercial payers that offer Qualified Health Plans (QHPs) in the Federally Facilitated Exchange (FFE) may not enroll PAs and instead require that claims for PA-provided services be submitted under a collaborating physician’s name and attributing all services to a physician. When this occurs, similar to when “incident to” billing is used, it is nearly impossible to accurately identify the type, volume, or quality of medical services delivered by PAs. As such, AAPA requests that, to improve a beneficiary’s ability to make care decisions using trusted data, the agency require all private payers with whom it contracts under the FFE, Medicare Advantage, and Medicaid Managed Care, to enroll PAs as rendering providers.

The ability to retrieve and use sound data regarding who provided what services is similarly essential for beneficiary access, even when beneficiaries themselves do not directly use the data. Decision makers rely on such data when determining the adequacy of provider networks, promoting provider policy compliance, sharing best practices, and tracking care outcomes. Accurate data and attribution of that data are also essential to “value-based care,” which CMS has identified in the RFI as “a cornerstone of CMS' strategy to incentivize improvements in health outcomes rather than increases in service volume.” Therefore, it is critical to improve beneficiary access to high-quality data, and CMS should work independently and in conjunction with Congress to improve accurate attribution of services.

Technology to Improve Beneficiary Interactions with Providers and Payers

Telehealth

Recent and evolving technologies have proven invaluable in enhancing the patient experience when interacting with health providers. The advent of patient portals and online scheduling has allowed for more streamlined communication processes that used to require lengthy and, at times, arduous processes.

The use of telehealth has similarly contributed to reduced patient burden, allowing patients to access care providers not immediately geographically available to them. Recent flexibilities in Medicare telehealth requirements have further broadened those instances in which telehealth can be used, extending the benefits of telehealth to a greater number of beneficiaries.

As a result of the COVID-19 pandemic, regulatory waivers and temporary, Congress-authorized flexibilities have allowed many services to be provided via telehealth with a patient's home serving as an originating site, and no need to be in a rural area. These flexibilities were extended under section 4113 of the Consolidated Appropriations Act of 2023, temporarily removing statutory restrictions on geographic location and site of service through the end of 2024, and then again by legislation through September 2025.

However, short of further Congressional intervention, as of October 1, 2025, Medicare beneficiaries receiving telehealth services will need to be in a rural area and in an approved medical facility for most services. The allowance for a patient to receive care in their home would be restricted to patients receiving behavioral or ESRD-related clinical assessments. Other statutorily-granted waivers have allowed providers at FQHCs and RHCs to continue to provide telehealth services, allowed certain services to be provided audio-only (as opposed to requiring a visual component), authorized telehealth to be used for the required face-to-face encounters before recertification for hospice care, and delayed the reimplementation of requirements that a patient receiving behavioral health services via telehealth must first have an in-person visit with their provider and periodically after.

AAPA has heard, anecdotally, that, even prior to the October 1 date, the lack of certainty over the ending of these flexibilities has led to more restrictive telehealth practices, limiting beneficiary care options. We believe the broader use of telehealth greatly expands patient access to services. As such, AAPA urges CMS to work with Congress to make these waivers permanent.

Timely Communications on Behalf of Patients

Direct communications between patients and third parties, such as providers and payers, are not the only communications that promise improved care experiences for beneficiaries. Clear, complete, and prompt communications between third parties would also benefit beneficiaries.

AAPA has previously supported APIs between providers and payers through a "Provider Access API" that would streamline the patient data exchange between payers and health professionals in the payer's network. Some examples of the types of data exchange that may occur through the Provider Access API include prior authorization determinations, adjudicated claims, and encounter data. AAPA finds great value in a Provider Access API to streamline communications between payers and health professionals. Ensuring an efficient and reliable method of

communication between payers and providers may expedite the receipt of information that health professionals need to provide care in a timely and efficient manner. We reiterate our support for this API.

However, AAPA suggests that to maximize patients' understanding of the prior authorization process and how their health data are being used, all transfers of information relevant to their health data that occur under the Payer/Provider and Payer/Payer APIs should also be documented and accessible under the Patient Access API. This would also support patients in determining whether they wish to opt out of having their information shared.

Artificial Intelligence and the Streamlining of Cumbersome Processes

AAPA supports further exploration of the role of artificial intelligence in streamlining specific processes that currently may delay access to care. In previous rules, CMS has suggested automating the decision as to whether prior authorization is required for an item or service, and if determined to be needed, requiring an automatic explanation of a payer's prior authorization requirements to providers. AAPA supported this idea as we believe automating the determination of whether prior authorization is necessary and removing the need to research each respective payer's prior authorization process requirements will save time on behalf of health professionals and patients.

The same rule went further by suggesting an API could automatically compile portions of the required information a payer needs that can be found in a health information system to process a prior authorization. The API would also provide time-saving potential for the payer, auto-populating certain information required to be included in a response to a prior authorization request, such as a reason for denial. AAPA expressed similar approval to these proposals. Properly implemented, increased automation may expedite the prior authorization process to benefit patients waiting to receive approval for care. We cautioned that any auto-population of information should not interfere with the workflow of the health professional while with a patient, but should instead collect the information for the provider to review and submit later. In addition, AAPA cautioned that responses to prior authorization requests should not be made fully automated, and that payers should be required to individually review each prior authorization request, including the auto-populated information. This would minimize the likelihood of false denials or approvals that would be overturned later by requiring someone to review the full context of a patient's medical condition submitted by health professionals, which may not always trigger the correct automatic determination.

Interoperability of Patient-Generated Data in Medical-Decision Making

A new trend being infused into the medical-decision making process is the integration of patient-generated health data using commercial software and wearable device technologies. These technologies may include, but are not limited to, the use of "wellness devices," which may measure biometric data such as heart rate, activity levels, and sleep patterns, and "personal emergency response systems" that may alert a caregiver or local emergency response services to a fall or elopement of an individual with memory impairment.[2] Medicare and Medicaid beneficiaries frequently present this data to their healthcare provider(s), which, subsequently, contributes to objective data reviewed during the medical-decision making process. Such data has been shown to not only improve patient satisfaction, but can significantly improve clinical outcomes and reduce post-operative complications.[3,4] For example, cardiac implantable electronic devices that monitor patients for arrhythmias (potentially life-threatening abnormal heart rhythms), can be programmed to deliver a life-saving defibrillation , all while storing the patient's data and interfacing with their health care provider.[5] Due to the benefits data from these devices may provide to medical decision making, as well as the potential for direct clinical interventions by such devices, CMS should develop additional information for health professionals regarding appropriate collection and utilization of such data. Standards for secure transfer, storage, and privacy of data from these devices may further legitimize and standardize this form of data collection. CMS may further wish to examine potential reimbursement options beyond existing and limited remote patient monitoring for review of this data, as well as distribute best practices for effective use, in order to proliferate acceptance of this emerging technology.

Mitigating Technological Burden

AAPA believes that CMS could support increased use of technology to benefit patients in several additional ways. First, as one significant barrier to using emerging technologies is often the burden of the initial adoption, the agency could offer direct technical assistance to those practitioners utilizing certain technologies to help in their adoption and optimization, as CMS has done so in the past with various required technologies. Second, as there may be limited awareness of many beneficial technologies available and their potential benefits and risks, CMS should widely report on promising or innovative technologies and best practices for technology implementation

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[2] Knight SR, Ng N, Tsanas A, Mclean K, Pagliari C, Harrison EM. Mobile devices and wearable technology for measuring patient outcomes after surgery: a systematic review. *NPJ Digit Med*. 2021;4(1):157. Published 2021 Nov 12. doi:10.1038/s41746-021-00525-1

[3] Ibid

[4] Nichols JH, Assad RS, Becker J, et al. Integrating Patient-Generated Health Data from Mobile Devices into Electronic Health Records: Best Practice Recommendations by the IFCC Committee on Mobile Health and Bioengineering in Laboratory Medicine (C-MHBLM). *EJIFCC*. 2024;35(4):324-328. Published 2024 Dec 30.

[5] Das S, Siroky GP, Lee S, Mehta D, Suri R. Cybersecurity: The need for data and patient safety with cardiac implantable electronic devices. *Heart Rhythm*. 2021;18(3):473-481. doi:10.1016/j.hrthm.2020.10.009

and use. Third, as data reporting requirements may vary depending on the data requested, CMS should offer multiple methods through which providers and payers may submit data to CMS and provide clearly identified submission requirements for each. Finally, considering that extensive data submission can often feel like a burden more than an important process, CMS may alleviate data reporting fatigue by providing clear justification for the requested data, illustrating how the data will be used to improve care accountability and beneficiary experience.

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as "Physician Assistants/Physician Associates," as recognized in 20 CFR § 220.46 (a)(9).[6] This accurately reflects PAs who currently graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or "physician associate," but who all graduate from programs accredited by the same accrediting organization (Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (National Commission on Certification of Physician Assistants), and have the same scopes of practice. Although the profession has been known as "physician assistant," the official title of the profession is now recognized as "Physician Associate" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of the AAPA, other professional organizations[7], professional training programs[8], and state and territory laws and licensure.[9] Despite the recognized title of "physician associate," it is anticipated to take some time for the title change from "physician assistant" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "physician assistant" and "physician associate" is recommended to avoid confusion. AAPA urges [agency/entity] to reference the profession by the dual title "physician assistant/physician associate."

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[6] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

[7] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. Examples: Connecticut Academy of Physician Associates https://connapa.org/aboutconnapa, Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com, Academy of Physician Associates in Cardiology https://www.cardiologypa.org, and Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org.

[8] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: Yale School of Medicine, Physician Associate Program, https://medicine.yale.edu/pa, Wichita State University, Physician Associate Program https://www.wichita.edu/academics/health_professions/pa/, Alvernia University, Physician Associate Program https://www.alvernia.edu/academics/ug/bio-pa.

[9] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregon-governor-tina-kotek-signs-law-changing-pa-title/. See also, Or. Rev. Stat. § 677. See also, Wis. Stat. § 448.974(1)(a)(2)-(6). See also, 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p).

Thank you for the opportunity to provide comments regarding the Improving Technology to Benefit Patients RFI. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have, please do not hesitate to contact Sondra DePalma, Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

Jason Prevelige, DMSc, MBA, PA-C, DFAAPA
President and Chair, Board of Directors