September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 115,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program proposed rule.

AAPA values the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments on proposed policy changes to the Medicare program. The Medicare program is currently undergoing a significant transition to a new, value-based payment and delivery structure, both through the implementation of the Quality Payment Program (QPP), as well as regular updates to the Physician Fee Schedule. We believe it is essential for CMS to receive input from the PA profession as PAs are instrumental in ensuring the Medicare program's success in providing timely, effective and efficient care to beneficiaries. It is within this context that we draw your attention to our comments regarding CMS' planned modifications to the Physician Fee Schedule for 2018. For your convenience, we have divided our comments according to topic.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the Physician fee Schedule (PFS)

In CMS' 2017 Outpatient Prospective Payment System (OPPS) Rule, the agency began to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that specific items and services provided by certain off-campus provider-based departments (PBDs) not be covered/reimbursed as outpatient department services. Instead, as a transitional policy, CMS proposed to reimburse for most of these services under Medicare's Physician Fee Schedule. Certain items and services such as emergency services, items and services billed prior to November 2, 2015, and items and services furnished in a hospital department that is within 250 yards of a remote location of the hospital, were excepted from this policy change. In our comments to the 2017 proposed rule, AAPA encouraged extensive dialogue and review as to the net impact of reimbursement changes on all affected stakeholders due to the magnitude and nuances of the change.

In CMS' 2018 Physician Fee Schedule proposed rule, the agency has proposed further modification to the PFS Relativity Adjuster, which will result in deeper cuts in reimbursement for non-excepted items and services furnished by non-excepted off-campus PBDs from 50% to 25% of the OPPS fee schedule. CMS indicated that the original reduction to 50% of the OPPS fee schedule was made to ensure adequate payment to these PBDs. However, CMS understood that the reduction was not significant enough to create payment parity with similar services delivered in private office settings and that an additional payment reduction would be necessary.

While AAPA understands CMS' intentions to reimburse at the same rate for similar work in similar practice settings for the sake of payment equity and to de-incentivize hospitals from purchasing physician offices in order to bill under the higher OPPS payment schedule, we caution against making this additional cut without ensuring that there in adequate data to support the reduction. By CMS' own admission, the agency does not yet have complete claims data from CY 2017, which it deemed necessary to guide CMS' approach. This current substantial decrease in reimbursement without the support of appropriate and complete data may not be warranted, and necessitates additional dialogue with relevant stakeholders regarding what impact this may have on non-excepted off-campus PBDs and their patients.

Until more complete data can be reviewed, AAPA recommends CMS set its PFS Relativity Adjuster at 40% of the OPPS fee schedule to make certain that adequate payment remains in place. An over-correction, which may lead to insufficient compensation of non-excepted off-campus PBDs and negatively impact their ability to provide care, would be a markedly worse option than the issuance of an unusually low PFS Relativity Adjuster rate until further data can be analyzed.

Patient Relationship Codes

Following multiple opportunities for public comment, CMS has selected an operational list of patient relationship categories and has now issued the corresponding HCPCS modifier codes. They are:

TABLE 26: Proposed Patient Relationship HCPCS Modifiers and Categories

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

Source: 2018 Physician Fee Schedule Proposed Rule

The MACRA legislation required that, starting January 1, 2018, all claims submitted for items and services furnished by an applicable practitioner include the appropriate codes established for care episode groups, patient condition groups, and patient relationship categories, as well as the NPI of the ordering practitioner. However, in the 2018 Physician Fee Schedule proposed rule, CMS has decided the reporting of these codes will instead be voluntary starting January 1, 2018.

While AAPA appreciates CMS' intent to work with clinicians to educate them about the proper use of patient relationship modifiers, we suggest that its attempt at flexibility by allowing the use/submission of these codes to be voluntary is misguided. CMS states it proposed this flexibility to provide an

adequate timeframe for health professionals to understand the appropriate use of these codes. AAPA suggests familiarity instead comes with practice and recommends that health professionals be encouraged to submit these codes after January 1, but CMS should assure practitioners that errors made in the use of these modifiers will not initially impact payment.

Further, in order to maximize CMS' stated goal of improved familiarity, AAPA reiterates our recommendation that the agency work with health professional associations, such as AAPA, to assist in the education of health professionals on the appropriate utilization of each patient relationship category. AAPA also maintains that a beneficial resource for CMS to employ in its efforts to educate health professionals on these codes would be an extensive set of clinical scenarios for each category that could act as real world examples to be used in webinars and in printed educational materials.

Finally, while AAPA is supportive of the fact that CMS has again stressed that medical services are to be attributable to the applicable practitioner, we remain concerned that billing provisions such as "incident to" may thwart this goal. AAPA requests the name and NPI of the applicable practitioner appear on the claim and be able to be tracked throughout the claims process for services billed "incident to." We encourage CMS to take seriously and make explicit that the need for accurate data through patient relationship codes, and the associated goal of "precise analysis of attribution," require that a PA's name and NPI be included on each "incident to" claim as the rendering provider.

Medicare Shared Savings Program Accountable Care Organization (ACO) Assignment

ACOs are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. PAs are listed by Medicare as one of three types of health professionals 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. Medicare beneficiaries treated solely by PAs and Nurse Practitioners (NPs) can't be assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA (or NP) is the only health professional in the community.

In the 2018 Physician Fee Schedule proposed rule, CMS again outlines its assignment policy. In the rule, CMS suggests that a patient who received care from a physician will be eligible for assignment to an ACO, in what is called the "pre-step." However, *which* ACO the beneficiary is ultimately assigned to will take into consideration the volume of services received from all ACO professionals, including PAs, under what is called the "first step."

While CMS does not include language that would permit a visit by a PA to trigger patient attribution to an ACO, we understand there is statutory language (42 CFR §425.402(a)) CMS must consider. AAPA requests CMS work with congress to change 42 CFR §425.402(a) to allow patient attribution to an ACO when the patient has received care only from a PA or NP.

Certified Rural Health Clinics (RHCs), required by law to be staffed by PAs, NPs or nurse midwives have been successful at extending healthcare to patients in rural, underserved communities. We are pleased CMS has proposed to include patient encounters that occur in RHCs visits that allow patients to gain attribution to an ACO. This policy, if finalized, will ensure that patients in rural communities have similar access to coordinated care models, such as ACOs, as patients in urban areas.

Medicare Telehealth Services

Expanded access to telehealth services has the potential to improve access to cost-effective, quality healthcare and improve clinical outcomes by facilitating interaction and consultation among health professionals. AAPA supports the addition of the suggested telehealth codes:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)

AAPA appreciates the fact that PAs are authorized to perform and be reimbursed for all Medicare-covered telehealth services. This capability gives PAs the ability to extend access to medical care to patient populations that may be without traditional access to services, thereby reducing health complications and hospitalizations and improving quality of life for Medicare beneficiaries. AAPA approves of a robust expansion of telehealth while maintaining standards of quality, and encourages CMS to continue to identify additional services that can safely and effectively be performed via telehealth.

Evaluation & Management (E/M) Guidelines

CMS suggests the current E/M guidelines may be outdated and may not be consistent with current practice, and requests suggestions for revisions to the documentation requirements. AAPA acknowledges that the E/M guidelines are over two decades old and revisions to the requirements could potentially reduce clinical burdens and improve documentation in a way that would be more effective for clinical workflow and care coordination. However, we anticipate like the last time revisions to the guidelines were attempted, it will be challenging to find consensus on new guidelines across different medical specialties and practitioner types.

AAPA supports giving a certain level of flexibility to individual practitioners as to the extent of documentation that is required for the history and physical exam, commensurate with establishing the diagnosis and management of the condition, and as needed for appropriate medical-legal documentation. However, substantially eliminating the need for documentation of the history and exam may also be problematic in that documenting the medical decision making could play too large a role. Rather than eliminating the need for history and exam, perhaps shifting more weight to medical decision making (MDM) would be in order.

AAPA would be interested in participating in a collaborative effort involving relevant stakeholders to consider reform of E/M documentation guidelines, should CMS undertake such an initiative.
Items regarding E/M documentation that deserve review, even if there is not a broad revision to the guidelines, include:

- Levels 4 and 5 new patient codes require an extensive history and exam (comprehensive) that may not be necessary in all circumstances when diagnosing a patient's condition. In addition, all three key components (history, exam and medical decision making) must be met or exceeded in order to bill at these levels. A review of the requirements for these two coding levels is justified.

- The current system for MDM and the associated point system that many payers utilize should be reviewed. For example, there's no real distinction between the types and severity of presenting problems. Currently a new problem is valued higher than an existing problem. The new problem might be a rash while the old problem might be a condition that is much more serious, such as congestive heart failure. Why automatically value a new condition as being of higher importance

than an existing medical problem? The table of risk discusses prescription medications, but there's no distinction between a relatively benign medication and one that has more significant consequences, side-effects or potential interactions with other medications.

- The level of risk or audit exposure to health professionals must be considered. Shifting to a more time-based E/M documentation methodology could put health professionals at greater risk for allegations of fraud and abuse if less information (history and exam) is being included in the medical record.

New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

Recognizing that under the physician fee schedule (PFS) additional codes are available for billing complex chronic care management (CCM), general behavioral health integration (BHI) and psychiatric collaborative care model (CoCM), CMS proposes to add two new G codes that RHCs and FQHCs may use to be reimbursed for the provision of care management services.

GCCC1 is a proposed General Care Management code for RHCs and FQHCs with the payment amount set at the average of the national, non-facility, PFS rate for CCM codes (99490, 99487 and BHI code G0507). GCCC2 is the proposed Psychiatric CoCM code with reimbursement set at the average, non-facility, PFS payment of psychiatric CoCM codes G0502 and G0503.

These care management services are reimbursed under Medicare Part B, separate from the more typical RHC all-inclusive rate and FQHC prospective payment system that are typically used for payment in these settings. Unfortunately, PAs providing services in PA-owned RHCs are unable to submit claims under Medicare Part B, even when they deliver medically-necessary, covered services. Consequently, PAs in these settings would be unable to receive reimbursement for these new care management codes and would be forced to deny providing these services to their patients or provide the service with no payment. AAPA requests CMS modify its existing policy that refuses to issue a Part B provider number to a PA who owns a RHC and allow PAs to bill for care coordination services and other important services provided to Medicare beneficiaries that are required to be billed to Medicare Part B. We strongly encourage CMS explicitly recognize that a PA-owned RHC is an entity separate and different from the individual PA owner. When services provided in a RHC are required by Medicare to be reimbursed by Medicare Part B it is only reasonable CMS provide a methodology for legitimate services to be reimbursed. RHCs by their very nature are in underserved communities often with a fragile financial structure. No RHC or PA who services this patient population should be placed in a situation in which they lose money because they choose to deliver a medically necessary service to a Medicare beneficiary.

Reducing Unnecessary Burdens

The Medicare program authorizes PAs to deliver medical services that would otherwise be provided by physicians. PAs are committed to providing the highest quality care for all Medicare beneficiaries. To accomplish that goal it is essential that Medicare's policies authorize PAs to practice to the top of their license. In addition, the program should eliminate any rules or regulations that obstruct the ability of patients to receive medically necessary care from PAs due to outdated or irrational policies that don't improve care quality or cost-effective care delivery.

In this document we have provided examples of Medicare policies that:

Disrupt continuity of care for patients: the inability of PAs, who might have been treating a patient for 15 years, to certify, order and deliver hospice care, and to certify and order home health services;

Hinder the Medicare program's transition toward value-based care delivery models by promoting the collection of poor data: lack of accurate data on PA-provided care, lack of direct payment to PAs and the inability for patients to join accountable care organizations if all of the patient's care is received from a PA or NP;

Increase administrative burdens without improving quality: requiring physician co-signatures on medical records after a patient has been treated by a PA and released from the hospital, and requiring a physician co-signature days after a PA has examined a patient and determined that they should be admitted to the hospital; lack of consistency in the application of Medicare coverage policies by state Medicare Administrative Contractors;

Reduce patient access to care especially in rural and underserved communities: the inability of PAs to supervise cardiac and pulmonary rehabilitation programs, order diabetic shoes, and order medical nutritional therapy services.

The following are statutory and regulatory burdens with proposed solutions:

1. Description: PAs are the only health profession not authorized to receive direct reimbursement from the Medicare program.

Summary:
PAs are the only health professionals authorized to bill Medicare for their services who can't receive direct reimbursement for those services. This barrier limits the flexibility of PAs to work in new and evolving practice and care models, and does not allow PAs to assign their reimbursement to other entities in the same manner as physicians, advanced practice nurses and other healthcare professionals such as physical therapists, anesthesiologist assistants, registered dieticians, occupational therapists, etc.

Related Statute/Regulation: 42 CFR §1395u(b)(6)(C)

Proposed Solution: Change statutory language to authorize PAs to receive direct payment from Medicare.

2. Description: Ensure that transparency exists for services delivered by PAs in the transition to value-based care delivery.

Summary:
One of the key components of the shift to value-based care delivery is the collection and analysis of accurate and actionable data dealing with quality, outcomes, resource allocation, and other factors. Due to Medicare's current claims processing system, the care provided by PAs is often attributed to physicians (i.e. "incident to"). PAs are essentially "hidden providers" when this occurs. This means that any payment system that seeks to assess quality and outcomes for health professionals such as PAs and NPs, and reimburse accordingly, is likely to be fundamentally flawed.

Related Statute/Regulation: "Incident to" billing requirement listed in the Medicare Benefit Policy Manual, Chapter 15 - Section 60.2

Proposed Solution: CMS should mandate that the name of the health professional who actually rendered patient care be listed and trackable in the Medicare claims system.

3. Description: PAs and NPs are not recognized by Medicare for purposes of certifying the need for, and ordering, diabetic shoes.

Summary:
PAs are already authorized to order durable medical equipment. The exclusion of diabetic shoes is a rare exception to this authority. PAs commonly manage the care of diabetic patients. Medicare, however, requires a physician to certify the need for diabetic shoes and requires a physician to order diabetic shoes. These Medicare requirements result in additional physician visits of a PA's diabetic patient, who is in need of diabetic shoes, so that a physician can fulfill Medicare's requirements for the certification and order. Authorizing PAs to certify and order diabetic shoes will improve access to care and eliminate unnecessary physician visits, certifications and orders.

Related Statute/Regulation: §1861(s)(12) of the Social Security Act

Proposed Solution: Change the statute to authorize PAs and NPs to certify the need for, and order, diabetic shoes. AAPA supports H.R. 1617, the Promoting Access to Diabetic Shoes Act, by Reps. Tom Reed (R-NY) and Earl Blumenauer (D-OR) that would remove this barrier for PAs and NPs.

4. Description: PAs are not recognized by the Medicare program for purposes of ordering home health and signing the home health plan of care.

Summary:
PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs (and NPs) for purposes of certifying or ordering home health services or signing the home health plan of care for these same patients. This inability to certify or order home health for Medicare patients leads to a lack of continuity of care for Medicare beneficiaries, especially in rural and underserved communities, because the patient's primary care provider, the PA, is unable to order medically necessary services for the patient. The inability to sign the plan of care results in the inability of PAs to write orders (i.e. writing prescriptions and ordering durable medical equipment) related to caring for their patient. Ensuring patients have the right level of care at the appropriate time often prevents an escalation in the patient's condition and the need for more acute and expensive healthcare services. Certifying the need for home health services is clearly within a PA's education, training and state law scope of practice.

Related Statute/Regulation: 42 USC §1395f(a), §1395n(a), §1395x(m), §1395x(o)(2), §1395fff

Proposed Solution: Change statutory language to allow PAs to certify, order and sign the plan of care for home health services. AAPA supports H.R. 1825, the Home Health Care Planning Improvement Act of 2017, introduced by Reps. Chris Collins (R-NY) and Jan Schakowsky (D-IL) that would remove this barrier for PAs and NPs.

5. Description: PAs are not recognized by Medicare for certifying a terminal illness, ordering hospice and functioning as an "attending physician" under the Medicare hospice program.

Summary:
PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs for certifying terminal illness, ordering hospice, and providing and managing (acting as an "attending physician") hospice services. This lack of PA recognition leads to a disruption in continuity of care for beneficiaries, especially in rural and underserved communities, because the patient's primary care provider, the PA, is unable to order medically necessary services for the patient. A patient is often most vulnerable when dealing with a terminal illness. It is especially unfair for a patient to lose the ability to work with, and be treated by, their primary medical provider during this uniquely difficult time. In addition, having a patient avoid a stay in an acute care setting as they are dealing with their hospice related condition will save the system money.

Related Statute/Regulation: 42 USC §1395x(dd)(3)(B), 1395f(a)(7)

Proposed Solution: Change statutory language to allow PAs to certify a terminal illness, order hospice and serve as an "attending physician". Partial fix would be achieved with passage of H.R. 1284, the Medicare Patient Access to Hospice Act, by Reps. Lynn Jenkins (R-KS) and Mike Thompson (D-CA) that would remove the barrier of PAs not being allowed to serve as an "attending physician."

6. Description: PAs are required to obtain a physician co-signature on hospital admission orders prior to a patient's discharge.

Summary:
Medicare policy permits PAs to write the admission order and perform a history and physical (H&P) to determine the necessity of an inpatient hospital admission. However, any such orders must be co-signed by a physician, potentially days later, prior to a patient's discharge from the facility. Requiring a physician to take the time to co-sign an admission order, after the PA's determination of medical necessity has already been deemed sufficient, is an inefficient use of a physician's time. If a physician is not available the patient's discharge may be delayed resulting in an increased length of stay in the hospital.

Related Statute/Regulation: CMS Transmittal 234

Proposed Solution: CMS should clarify that when a PA orders a hospital admission a physician is not required to co-sign the admission order.

7. Description: PAs are required to obtain a physician co-authentication (co-signature) on hospital (inpatient and outpatient) discharge summaries.

Summary:
When a PA discharges a patient from the hospital, a physician's co-signature is required on the

discharge summary within 30 days of the patient's discharge. This must be done for all hospital inpatient and observation stays, emergency department services, and hospital outpatient department services. Requiring that all discharge summaries be co-signed by a physician is an enormous administrative burden for facilities and an inefficient use of a physician's time. There is no clear value being provided to the patient or the healthcare system from this requirement.

Related Statute/Regulation: CMS State Operations Manual, Appendix A, Section 482.24(c)(4)(vii)

Proposed Solution: CMS should modify regulatory language to remove the requirement for physician co-authentication of a discharge summary.

8. Description: The lack of consistency in the application of national Medicare coverage and reimbursement policies by state Medicare Administrative Contractors creates confusion in the ability for health professionals and health systems to follow Medicare policy.

Summary:
Medicare Administrative Contractors (MACs) are contracted to implement national Medicare policy at regional levels. However, ambiguous Medicare regulations have led MACs to vary in their interpretations of certain national Medicare policies, and thus have resulted in different policy implementations by different MACs. Consequently, equivalent health professionals are currently subject to varying rules rooted in the same statute or regulations, based on divergent MAC interpretations.

Related Statute/Regulation: Medicare requirements for Shared Visit billing can be found in the Medicare Claims Processing Manual, Chapter 12, 30.6.1.B

Proposed Solution: CMS should identify and actively respond to reports of discrepancies between Medicare Administrative Contractor interpretations of national Medicare policies and correct any ambiguous language in order to foster more uniform implementation of CMS coverage policy.

9. Description: PAs are not recognized by Medicare for purposes of supervising cardiac, intensive cardiac, and pulmonary rehabilitation programs.

Summary:
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 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.

Related Statute/Regulation: §1861(eee) of the Social Security Act

Proposed Solution: Change the statute to allow PAs to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs. AAPA supports H.R. 1155, bipartisan legislation by Reps. Lynn Jenkins (R-KS) and John Lewis (D-GA) that would resolve this barrier.

10. Description: PAs are not recognized by Medicare as being able to supervise other health personnel who perform diagnostic tests.

Summary:
PAs are authorized to request and perform diagnostic tests consistent with their state law scope of practice. However, only a physician may supervise the performance of these tests by ancillary staff. PAs are highly qualified, by training and education, in the performance of diagnostic tests, as well as in emergency services that may be required during testing. Authorizing PAs to supervise diagnostic tests will improve efficiency in the healthcare system by and expanding access to care.

Related Statute/Regulation: Program Memorandum Carriers, Transmittal B-01-28, Change Request 850, April 19, 2001; and 42 CFR §410.32(b)

Proposed Solution: CMS policy should authorize PAs to supervise diagnostic tests within their state law scope of practice when performed by other office technicians/certified personal.

11. Description: Medicare requires that PAs in certified rural health clinics (RHCs) provide certain diagnostic services, but does not create a method for the PA to be reimbursed for these mandated services.

Summary:
Federally certified RHCs must have a PA, nurse practitioner or certified nurse midwife staff the clinic 50 percent of the time the clinic is open. Medicare requires RHCs to offer specific diagnostic tests to be performed in RHCs. Unlike the payment methodology for the typical RHC patient visits, these diagnostic services require billing and reimbursement through Medicare Part B. Medicare does not allow direct payment to PAs through Part B. Therefore, PA RHC owners are not paid for these required services and that lack of payment could threaten the financial viability of the RHC. PAs are essential healthcare providers in RHCs and Medicare should provide a means to assure payment to PA RHC owners for required Part B services.

Related Statute/Regulation: 42 CFR 491.9

Proposed Solution: CMS should require that a payment method be established when PAs in RHCs are performing CMS-mandated diagnostic tests to beneficiaries (such as authorizing Medicare to provide direct payment to PAs – see #1 priority).

12. Description: Medicare patients being treated solely by a PA or an NP cannot be included in an accountable care organization (ACO) unless they have at least one visit with a physician.

Summary:
ACOs are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. PAs are listed by Medicare as one of three types of health professionals 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. Medicare beneficiaries treated solely by PAs and NPs can't be 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.

Related Statute/Regulation: 42 CFR §425.402(a)

Proposed Solution: Change the statute to allow patient attribution to an ACO when the patient has received all of their medical care solely from a PA or an NP. AAPA supports H.R. 1160, the ACO Assignment Improvement Act of 2017, introduced by Reps. Derek Kilmer (D-WA) and Lynn Jenkins (R-KS) that would remove this barrier.

13. Description: PAs are not authorized to participate in or lead the interdisciplinary team for the Programs for All-Inclusive Care for the Elderly (PACE) program.

Summary:
CMS issued a proposal that would authorize PAs (and NPs) to be members of interdisciplinary teams as part of the Programs for All-Inclusive Care for the Elderly (PACE) thereby reducing administrative burdens and increasing patient access to care. However, the overarching final rule has been held up for regulatory review.

Related Statute/Regulation: Programs of All-Inclusive Care for the Elderly (PACE) Manual - Chapter 8 – IDT, Assessment & Care Planning - Section 10.1.

Proposed Solution: Change the statute to authorize PAs to participate in and lead the interdisciplinary team for the PACE program. *Note: CMS has proposed to authorize PAs be able to provide services within the PACE program in a proposed rule (File Code-CMS-3295-P; Medicare and Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care). The final rule has not been released so it is unclear how the final rule would come out on this issue or if the rule will be released.*
Language to include PAs is contained in proposed rule CMS 4168-P

14. Description: Medicare uses the confusing term “licensed independent practitioner” when referring to those health professionals who are authorized to order restraint and seclusion in hospitals. This confusion can cause PAs not to be able to order restraint and seclusion.

Summary:
CMS issued language as part of a proposed rule that would remove confusing language in Medicare regulations that designates health professionals as licensed independent practitioners (LIP). CMS proposed to eliminate this term and replace it with the term “licensed practitioners” which would allow PAs to practice in accordance with their state license, thus reducing administrative burdens and increasing patient access to care. However, the overarching final rule has been held up in regulatory review.

Related Statute/Regulation: Hospital Conditions of Participation (CoP);

Proposed Solution: CMS should eliminate the term "licensed independent practitioner" and use "licensed practitioner" or refer to the specific health professional being discussed to avoid confusion.

Note: CMS has proposed to eliminate LIP language in a proposed rule (File Code-CMS-3295-P; Medicare and Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care). The final rule has not been released and it is unclear how the final rule would come out on this issue or if the rule will be released.
language to eliminate LIP language is contained in proposed rule CMS 3295-P

15. Description: PAs are limited by regulation and interpretation from providing certain inpatient hospital psychiatric services.

Summary:
PAs provide psychiatric services to Medicare patients in outpatient settings, consistent with state law scope of practice. Inpatient psychiatric services, however, are highly restricted, as patients are required to be under a physician's supervision and progress notes must be recorded by an MD/DO. These restrictions create delays and inefficiencies in the care and treatment of inpatient psychiatric patients. Authorizing PAs to provide and document care to patients in psychiatric hospitals would improve access to care for these patients.

Related Statute/Regulation: Medicare Benefit Policy Manual Chapter 2 – Inpatient Psychiatric Hospital Services; Sections 30.2.1.1 and 30.2.1.2 restricts PA certification/recertification

Proposed Solution: Remove regulatory restrictions regarding services PAs may perform and document in psychiatric hospitals.

16. Description: PAs are not recognized by Medicare as being able to order medical nutritional therapy (MNT).

Summary:
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. 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. Authorizing PAs to order these services will improve care for patients while reducing administrative burdens and inefficiencies.

Related Statute/Regulation: 42 CFR § 410.132

Proposed Solution: Change the statute to authorize PAs to order MNT. Language in the Social Security Act reads as follows: (vv)(1) 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)). We suggest adding "or a PA (as defined in subsection (aa)(5))" after (r)(1).

17. Description: PAs are not recognized by the Medicare program for purposes of interpreting the results of a screening mammography.

Summary:
The Social Security Act limits the interpretation of results of a screening mammography to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type "that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO)" including the ordering, performing, and interpreting of diagnostic tests. A delay in interpretation can cause unnecessary stress to a patient and potentially delay referral to an appropriate provider if results are abnormal. Delay in care could also affect healthcare efficiency, increase cost of care, and result in health complications.

Related Statute/Regulation: §1861(jj) of the Social Security Act

Proposed Solution: Change the statute to authorize PAs to interpret the results of a screening mammography. Language in the Social Security Act reads as follows: "(jj) The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure." We suggest adding "or PA's" after the word physician.

18. Description: PAs are not recognized by the Medicare program for purposes of interpreting bone mass measurement results.

Summary: The Social Security Act limits the interpretation and reimbursement of bone mass measurement to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type "that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO)" including the ordering, performing, and interpreting of diagnostic tests. Without timely interpretation, appropriate care to Medicare beneficiaries may be delayed. Delayed treatment of osteopenia/osteoporosis and initiation of fall prevention behaviors could result in falls and fractures, increased hospitalizations, avoidable procedures, increased health care costs, and disability.

Related Statute/Regulation: §1861(rr)(1) of the Social Security Act

Proposed Solution: Change the statute to authorize PAs to interpret bone mass measurement results. Language in the Social Security Act reads as follows: "(2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure." We suggest adding "or PA's" after the word physician.

19. Description: PAs are not recognized by Medicare for purposes of performing the comprehensive visit, and the required alternating physician mandatory visits, in skilled nursing facilities (SNFs).

Summary:
For many years, PAs have been authorized to deliver care to Medicare beneficiaries in SNFs. However, PAs are not recognized by Medicare regulation for purposes of performing the comprehensive visit to SNF patients. Also, PAs and physicians are required to alternate every other required visit to SNF patients. There is no reason and no medical evidence that would support such restrictions on PAs (and

NPs) from performing the comprehensive SNF visit and each required visit. This Medicare requirement is simply a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system.

Related Statute/Regulation: Memorandum Ref: S&C: 13-15-NH

Proposed Solution: CMS should remove regulatory restrictions and authorize PAs to perform the comprehensive visit, as well as to perform all required visits, in SNFs.

Conclusion

Thank you for the opportunity to provide feedback on the 2018 proposed PFS rule. AAPA welcomes further discussion with CMS regarding our positions and comments. For any questions you may have in regard to our comments and recommendations please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

L. Gail Curtis, MPAS, PA-C, DFAAPA
President and Chair of the Board