September 24, 2019

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

Re: CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Updates to the Quality Payment Program CMS–1715–P

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 131,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Center for Medicare and Medicaid Services' (CMS) 2020 Physician Fee Schedule and Quality Payment Program rule.

PAs are authorized to provide medical and surgical care to Medicare beneficiaries in all 50 states and the District of Columbia. PAs are committed to increasing access to high quality care for all Medicare beneficiaries and we seek to work in partnership with CMS in both the development and advancement of thoughtful policies that help in achieving that goal. To achieve this objective, it is essential Medicare's policies authorize PAs to practice at the top of their education and expertise. It is within that context we draw your attention to our comments.

Aligning Medicare PA Policies with State Law

AAPA applauds CMS' proposed language that would modify Medicare's physician supervision requirement to defer to state law regarding how PAs practice with physicians and other members of the healthcare team.

State-initiated healthcare reforms are particularly effective because they can be designed to meet the distinct needs of each state based upon its size and demographics, the blend of urban versus rural populations, the availability of health professionals and the location and availability of healthcare facilities. As states seek to address their healthcare workforce needs, many are pursuing legislative

changes in order to modernize PA practice. Some state law changes have replaced the outdated term "supervision" with other terms, such as collaboration, to be more reflective of current PA practice. Other states may authorize the PA's employer and/or employing facility to determine how PAs, physicians and other members of the healthcare team interact clinically. Still other states, such as North Dakota, have eliminated the legal requirement for a specific relationship between a PA, physician or any other health care provider in order for a PA to practice to the full extent of their education, training and experience. Presently, 11 states have passed legislation removing the term supervision to describe how PAs practice. More states are expected to follow this trend.

The December 2018 federal government report on healthcare competition entitled, "Reforming America's Healthcare System Through Choice and Competition," specifically recommended that "States should consider eliminating requirements for rigid collaborative practice and supervision agreements . . . that are not justified by legitimate health and safety concerns." States are heeding that message and it is essential the federal Medicare program promote regulations that closely align with those state PA legislative and regulatory changes to ensure continuity of care for Medicare beneficiaries.

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, recently removed the requirement for a PA to have a supervisory physician. IHS requirements for PA practice now state that the PA's clinical privileges shall be commensurate with their education, experiences, competencies, and operational needs for the service to which they are assigned.

It is essential for Medicare's PA practice requirements and state PA laws to be in alignment. While not altering PA scope of practice, these state-based changes will ensure PAs are authorized to practice to the top of their license, education and expertise, with the net result being increased patient access to care. This modification in Medicare policy would be similar to Medicare's regulatory requirements that have been in place for many years for nurse practitioners.

However, AAPA does have concerns about one aspect of the proposed CMS language. Specifically, CMS states that "In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services." This language could suggest that such documentation would have to appear in every medical record of every patient a PA treated. This would be a tremendous additional administrative burden that would have a negative impact on the ability of PAs to deliver care. AAPA suggests in the absence of state law governing physician supervision of PA services "a PA should document at the practice the relationship that they have with physicians to deal with issues outside their scope of practice."

PAs are qualified to practice with increased responsibility and autonomy. PAs, practicing within their state scope of practice, provide healthcare to patients on a qualitative level that is comparable to physicians, confirmed both by independent research studies spanning decades and by the range of medical and surgical services PAs are authorized to perform under programs such as Medicare.

PA education is rigorous and comprehensive. The typical student accepted into a PA educational program has a bachelor's degree and nearly three years of healthcare experience. PA program applicants must complete at least two years of college courses in basic science and behavioral science prior to entering a PA program. This is analogous to pre-med studies required of medical students. The average length of PA education programs is about 27 months or three academic years. PA education begins with a year of basic medical science courses (anatomy, pathophysiology, pharmacology, physical diagnosis, etc.). Following the basic science and medical science classroom work, PA students enter the clinical phase of training. This includes classroom instruction and clinical rotations in medical and surgical specialties (family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry). PA students complete at least 2,000 hours of supervised clinical practice prior to graduation.

Once PAs graduate from an accredited PA educational program, they are eligible to take the Physician Assistant National Certifying Examination (PANCE) to receive national certification from the National Commission on Certification of Physician Assistants (NCCPA), an independent certifying body. All states require that PAs pass the initial national certifying examination as a condition for licensure. Passage of this exam verifies that a graduate from an accredited PA program has demonstrated an appropriate level of medical knowledge.

In order to maintain certification after passage of the initial certifying exam, PAs are required to earn and log a minimum of 100 credits of continuing medical education (CME) every two years.

In terms of medical practice, PAs obtain medical histories, conduct physical exams, diagnose and treat illnesses, order and interpret tests, perform medical procedures, counsel patients on preventive healthcare, assist in surgery, write prescriptions, and make rounds in nursing homes and hospitals, among other medical services. PAs deliver a wide range of medical and surgical services in all practice settings, in both primary and specialty care.

Numerous studies have determined that the quality of care PAs provide is comparable to that of physicians in terms of patient safety and care outcomes.[1,2,3,4] Oversight bodies, such as medical boards, and hospitals with credentialing, privileging and by-laws, act as an already existing check on safety of care provided by PAs and other health professionals. Studies have demonstrated no significant difference in adverse events, hospital lengths of stay, readmissions, or transfers to intensive care with PAs compared to physicians providing inpatient care.[5,6,7] In addition, PAs perform procedures with similar outcomes as physicians.[8,9,10] Another study demonstrates that PAs care for patients who have

[1] Doan et al., 2011 http://dx.doi.org/10.1111/j.1742-6723.2010.01368.x
[2] Ho et al., 2010 http://dx.doi.org/10.1111/j.1445-2197.2010.05311.x
[3] Mains et al., 2009 http://dx.doi.org/10.1097/TA.0b013e31819d96d8
[4] Virani et al., 2015 https://www.ncbi.nlm.nih.gov/pubmed/26483105
[5] Dhuper & Choski, 2009 http://dx.doi.org/10.1177/1062860608329646
[6] Roy et al., 2008 http://dx.doi.org/10.1002/jhm.352
[7] Singh et al., 2011 http://dx.doi.org/10.1002/jhm.826
[8] Bevis et al., 2008 Retrieved from http://ajcc.aacnjournals.org

similar medical complexity as patients treated by physicians.[11] similar outcomes as physicians.[12,13,14] Another study demonstrates that PAs care for patients who have similar medical complexity as patients treated by physicians.[15]

Patient satisfaction with care provided by PAs is also extremely high, with patients indicating not only that PAs are trusted healthcare professionals, but also that PAs provide excellent services.[16,17, 18,19]

In summary, a PA's education, training, certification and continuing medical education requirements ensure that they are qualified and capable of delivering the highest quality care to Medicare beneficiaries.

The proposed CMS policy change of aligning federal Medicare PA policy regarding supervision with state law, with the appropriate modification eliminating the need for specific documentation on the medical record, will ensure that PAs can continue to provide quality care and, in fact, increase access to care for Medicare beneficiaries. Failure to adopt this policy change could severely hinder beneficiary access to PA-provided care. We strongly encourage the agency to adopt this proposal in the final rule to assist states in meeting their healthcare workforce needs.

Hospice Care and PAs

Previously, statutory language was restrictive regarding the ability of PAs to provide care to hospice patients, prohibiting PAs from acting as a hospice patient's "attending physician," despite the fact that PAs frequently function as a patient's primary health professional. Comparable health professionals, such as nurse practitioners (NPs), had previously obtained legislative authority to serve as hospice "attending physicians." Changes in federal legislation (the Medicare Patient Access to Hospice Act as part of the Bipartisan Budget Act of 2018), and subsequent CMS regulation, broadened the Medicare definition of hospice "attending physician" to include PAs as of January 1, 2019. We appreciate CMS issuing regulations implementing a legislative provision that authorized PAs to be "attending physicians" in the Medicare hospice program.

While the implementation of hospice "attending physician" status for PAs is a significant step forward,

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[9] Horton et al., 2011 http://www.aanp.org/publications/jaanp
[10] Krasuski et al., 2003 http://dx.doi.org/10.1002/ccd.10491
[11] Ellen T. Kurtzman et al., 2017 https://www.aapa.org/download/21803/
[12] Bevis et al., 2008 Retrieved from http://ajcc.aacnjournals.org
[13] Horton et al., 2011 http://www.aanp.org/publications/jaanp
[14] Krasuski et al., 2003 http://dx.doi.org/10.1002/ccd.10491
[15] Ellen T. Kurtzman et al., 2017 https://www.aapa.org/download/21803/z
[16] Hooker et al., 2005 https://www.researchgate.net/publication/265445650
[17] Cipher et al., 2006 Retrieved from http://journals.lww.com/jaapa/pages/default.aspx
[18] Roblin et al., 2004 https://journals.lww.com/lww-medicalcare/Abstract/2004/06000/Patient_Satisfaction_With_Primary_Care__Does_Type.10.aspx
[19] Counselman et al., 2000 http://www.ajemjournal.com/article/S0735-6757%2800%2918497-9/abstract?cc=y

language in an outdated Medicare Hospice Condition of Participation (CoP), 42 CFR 418.106(b), prohibits PAs from ordering medications for hospice patients, severely constraining PAs from fully functioning in their new role and hindering access to hospice services for patients who are often at the most vulnerable stage of their lives. Language in the proposed 2020 Physician Fee Schedule (PFS) seeks to partially rectify this barrier, modifying the restrictive hospice CoP to permit PAs who are attending physicians and not employed by a hospice to order medications for Medicare hospice patients if those medications are unrelated to the patient's terminal illness.

AAPA appreciates this proposed change that would permit PAs acting as hospice attending physicians to order certain medications for hospice patients. This will allow PAs to better fulfill their duties in the role of attending physicians. However, regulatory impediments to efficient provision of care remain. Specifically, in the 2020 PFS Proposed Rule, CMS indicates that any attending physician (PA, NP or physician) is unable to order medications related to a hospice patient's terminal illness. Instead, it is suggested by CMS that an attending physician's function is to advise and support care coordination. However, the role of an attending physician does not end with the transition to hospice, but rather attending physicians are selected to work with the interdisciplinary group to establish and update a patient's plan of care and for continued assessment of a hospice patient. As such, constraints against the ability of an attending physician to order medications related to a hospice patient's terminal illness are prohibitive of their expected role and function.

In addition, in the 2020 PFS proposed rule, CMS places conditions on the ability of PAs to prescribe (i.e. PAs must be attending physicians and may not be employed by a hospice), but does not apply similar restrictions to physicians and NPs. This allows those physicians and NPs who are not acting as attending physicians and who are employed by a hospice to order medications for hospice patients. While CMS finds no objection to PAs being employed by a hospice and participating as part of a hospice interdisciplinary group, CMS suggests that only physicians and NPs in this role may order medications for hospice patients, while PAs on an interdisciplinary group may not. CMS indicates the reason PAs are restricted from ordering medications when employed by a hospice, while physicians and NPs are not, is due to the fact that the role of PAs is not defined in the hospice CoPs as their services are not explicitly included in statute as being part of the Medicare hospice benefit. CMS provides the example that NPs were included in the hospice CoPs due to the requirement in section 1861(dd)[20] of the Social Security Act to provide nursing services as part of a hospice benefit. There is similar mention in this section of physician services. While PAs are not included as one of the required members of the interdisciplinary team, they are authorized to provide care as part of the interdisciplinary group. In addition, according to Chapter 15[21] of the Medicare Benefit Policy Manual, services provided by PAs are "the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO)." Consequently, PAs employed by a hospice should be permitted to prescribe under a similar authority that granted NPs the ability, recognizing that PAs are authorized by Medicare to provide physician services.

[20] https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[21] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

The exclusion of PAs from this interpretation of Section 1861(dd) has likely contributed to another obstacle to patient-centric care. In Chapter 9[22] of the Medicare Benefits Policy Manual, it is noted that if a beneficiary does not have an attending physician, NP, or PA who provided primary care to them prior to, or at the time of, terminal illness, the beneficiary is given the choice of being served by either a physician or NP who works for the hospice. In other words, PAs may hold the status of hospice attending physicians, but PAs are not granted the ability to act as a substitute for the same role in the absence of a predetermined attending physician. AAPA finds this disconnect illogical and restrictive of patient choice.

As a result of these obstacles to PA practice under hospice, AAPA requests three additional changes to CMS regulations. First, CMS should make all necessary modifications, whether regulatory or in its interpretation, to permit "attending physicians," whether PAs, NPs or physicians, to provide orders for hospice patients that are related to their terminal illness. An attending physician, as the health professional chosen for coordination and continuity, as well as the professional who is frequently most familiar with the patient and their preferences, may be best equipped to provide such orders in concert with the hospice team when appropriate. A patient may also prefer the attending physician personally make any such orders as the attending physician may be the only health professional known, chosen, or most trusted by the patient.

Second, CMS should authorize PAs employed by a hospice to prescribe medications to Medicare hospice patients, similar to hospice-employed physicians and NPs. PAs are an integral part of care delivery teams, and the same is true of a hospice interdisciplinary group. In a time of worsening physician shortages, health professionals such as PAs will be increasingly relied upon to fill the access to care gaps. Helen McNeal, Executive Director of The California State University Shiley Institute for Palliative Care affirms this when she stated, "Physician assistants are an important and under-utilized group of health care providers that can help to address the shortage of qualified palliative care professionals." It is essential PAs be permitted to practice to the full extent of their education and expertise. Patients electing the Medicare hospice benefit should not be denied efficient and continuous provision of care because they are being treated by a PA.

As was mention in an earlier section of our comments, PAs are highly qualified and educated to provide care to Medicare patients in general and the hospice population, in particular. The typical student accepted into a PA educational program has a bachelor's degree and nearly three years of healthcare experience. PA program applicants must complete at least two years of college courses in basic science and behavioral science prior to entering a PA program. The average length of PA education programs is about 27 months or three academic years. *In addition to basic medical science courses and clinical training that includes both classroom instruction and clinical rotations, as part of PA national accreditation requirements, all PAs are required to have palliative skills and end-of-life training.* PA students complete at least 2,000 hours of supervised clinical practice prior to graduation. Once PAs graduate from an accredited PA educational program, they are eligible to take the Physician Assistant

[22] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

National Certifying Examination (PANCE) to receive national certification from the National Commission on Certification of Physician Assistants (NCCPA), an independent certifying body. All states require that PAs pass the initial national certifying examination as a condition for licensure. In order to maintain certification after passage of the initial certifying exam, PAs are required to earn and log a minimum of 100 credits of continuing medical education (CME) every two years. A PA's education, training, certification and continuing medical education requirements ensure that they are well-qualified and capable of delivering comprehensive, high quality care to Medicare hospice patients.

Finally, CMS should allow a beneficiary to have the option to select a PA who works for a hospice when the patient does not have a previously established attending physician. This would grant beneficiaries greater choice in choosing who they feel comfortable with consulting in their care decisions.

Meanwhile, AAPA continues to note other outdated hospice constraints on the PA provision of patient care. AAPA remains concerned regarding the inability of PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days. The statutory omission of PAs from being able to provide the face-to-face encounter falls short of continuity of care goals. Hospice patients should be able to receive care, such as the face-to-face encounter for re-certification, from a PA who has known and treated the patient. While AAPA continues to seek legislative modification to resolve this situation, we request that CMS explore any regulatory options to remedy this problem.

In addition, there are some aspects of hospice care PAs are still not permitted to provide that are currently reserved for a physician. For example, only a physician or medical director may certify terminal illness, only a medical director may admit a patient to a hospice, and PAs cannot take the position of a physician as one of the required members of an interdisciplinary group These restrictions apply to NPs as well.

AAPA believes the continued existence of these barriers to efficient care may negatively affect the experience of the most vulnerable patient population. AAPA requests that CMS communicate to Congress the increase in efficiency that would result from allowing PAs and NPs to certify and recertify terminal illness, admit a patient to hospice, and act in the capacity of a required member on an interdisciplinary group in place of a physician. AAPA also requests that CMS support a change in statute to allow PAs to perform any required face-to-face encounters.

CMS should authorize PAs employed by a hospice to prescribe any medically necessary medications to Medicare hospice patients. CMS should allow a beneficiary to have the option to select a PA who works for a hospice when the patient does not have a previously established attending physician. CMS should explore regulatory options and support a change in statute to allow PAs to perform face-to-face encounters prior to recertification. CMS should communicate to Congress the increase in efficiency that would result from allowing PAs and NPs to certify and recertify terminal illness, admit a patient to hospice, and act in the capacity of a required member on an interdisciplinary group in place of a physician. Finally, CMS should acknowledge the ability of "attending physicians," whether a PA,

NP or physician, to provide medication orders and other orders for hospice patients that are related to their terminal illness.

Medical Record Documentation

AAPA appreciates the CMS proposal to be inclusive of all members of the care team regarding documentation in the medical record. We believe that specifically clarifying 1) the ability of PAs (physician assistants) and APRNs (advanced practice registered nurses) to train/precept PA, APRN, medical and other students, and 2) that the documentation of PA, APRN, medical and other students can be reviewed and verified (and not re-documented) by PA and APRN preceptors on the medical record for billing purposes will increase the efficiency of health care teams and increase the willingness of practicing health professionals to precept students. The availability of training and clinical learning opportunities for these students is a crucial component of ensuring a robust and competent healthcare workforce.

Previously, CMS made attempts to reduce administrative burdens regarding the training and preceptorship of students. Transmittal 3971, and, subsequently, Transmittal 4068, was intended to be a step forward by allowing teaching physicians to verify, rather than re-perform, documentation provided by students. Interpretations of those transmittals, which suggested that PA and APRN preceptors could not similarly verify PA/APRN student documentation, harmed the ability to train PA and APRN students. Rather than eliminating administrative barriers, this clarification instead compelled health systems, hospitals and practices to reexamine their policies regarding the training of PA/APRN students due to the assumed additional preceptor work, namely the redocumentation of PA/APRN student contributions, involved with training PA and APRN students.

CMS proposes to establish a "general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by made by physicians, residents, nurses, students or other members of the medical team." AAPA commends the proposed change to eliminate disparities among physicians, PAs and APRNs and medical, PA, and APRN students.

AAPA notes that the purpose of the language revisions to medical documentation are meant to facilitate improved training opportunities for students and to reduce documentation administrative burdens overall. We would not expect these policy revisions to be interpreted as authorizing physicians, for example, to verify and utilize the documentation from evaluation and management services personally performed by licensed, practicing PAs and bill the service under the physician's name and NPI. Such billing patterns could lead to practice inefficiency, patient confusion as to which health professional was the provider of care and increased cost to the Medicare program (due to the 15% payment differential between PAs/ APRNs and physicians). Allowing a physician to review and verify the documentation of a licensed PA or APRN would circumvent existing Medicare requirements in place for split/shared services and "incident to" billing.

In addition, we urge CMS to use more explicit terminology in the final Physician Fee Schedule rule to eliminate any future confusion among key stakeholders. Specifically, the medical record documentation language in §§ 410.20 (Physicians' services), 410.74 (PA services), 410.75 (NP services), 410.76 (CNS services), and 410.77 (CNM services) should explicitly include physician assistants and advanced practice registered nurses rather than including these providers as eligible "other members of the medical team." Similarly, due to the current ambiguous definition of "student," these sections should specifically state that all preceptors can utilize the verified documentation of **medical, PA, and APRN students**.

Ensuring that PA and APRN preceptors can function in a similar manner to teaching physicians regarding the use of student documentation in the medical record and clarifying that PA and APRN student documentation, like medical student documentation, can be used by PA, APRN and physician preceptors for billing purposes will greatly facilitate educational and clinical training opportunities for PA, APRN, medical and other students. Removing administrative and regulatory barriers to training these students will lead directly to improved access to quality care for Medicare beneficiaries and all patients.

AAPA supports CMS' proposal to authorize 1) PA, APRN, medical and other student documentation to be utilized on the precepting PA's, APRN's or physician's medical record, and 2) the ability of PA and APRN preceptors to review and verify, rather than re-perform, documentation provided by PA, APRN, medical and other students. CMS should be mindful of potential unintended consequences with increased documentation flexibility and establish guidelines to prevent situations in which one licensed health professional appropriates the professional work product of another licensed health professional and bills that work product as their own.

Ambulatory Surgical Centers (ASCs) and PAs

ASCs have regulatory standards pertaining to patient pre-surgical assessment, post-surgical assessment, and discharge requirements that must be met before patients leave the ASC, which often require physician evaluation. In an attempt to reduce regulatory burden and allow qualified clinicians to provide high-quality healthcare to patients, CMS proposes to allow certified registered nurse anesthetists (CRNAs) to meet the regulation that requires an examination of the patient immediately before surgery to evaluate the risk of anesthesia and the risk of the procedure to be performed. CMS also requests suggestions for other ASC requirements that could be revised to allow greater flexibility in the use of PAs, NPs, and Clinical Nurse Specialists.

ASCs have limitations and restrictions that do not exist in hospitals, physician offices, and many other settings. PAs, like physicians, should be able to evaluate patients before surgery and prior to discharge, perform procedures, determine if a patient may be discharged without the company of a responsible adult and provide necessary follow-up care, all of which are currently restricted to physicians. PAs should also be able to administer blood and blood products, which according to current regulations, may only be administered by a physician or registered nurse. These responsibilities are consistent with PA education, training and scope of practice, and are being performed with high-quality and safely in non-ASC settings.

Allowing PAs to provide these services will expand patient access to needed care, as patients will no longer have to wait to see a physician when a clinically capable PA is available. In addition to increasing access, if an ASC is able to determine which health professional is most appropriate to see a patient based on factors such as qualification and availability, as opposed to making clinician allocation decisions based on a restrictive regulation, the ASC would be provided increased flexibility to operate in the most efficient manner possible.

AAPA recommends that CMS provide greater flexibility for PAs to provide high-quality healthcare in ASCs by eliminating current practice prohibitions contained in various ASC Conditions for Coverage guidelines and allowing PAs to evaluate patients before surgery and prior to discharge, perform procedures, administer blood and blood products, determine if a patient may be discharged without the company of a responsible adult, and provide necessary follow-up care.

Addition of PAs to the Open Payments Program

The Open Payments program requires the public reporting of financial relationships between health professionals and the medical device and pharmaceutical industries. These industries are required to report payments and transfers of value, monetary and otherwise, to those providers considered "covered recipients." Previously, the term "covered recipients" was defined to include only physicians and teaching hospitals. However, as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), CMS is revising regulatory language to add other health professionals, including PAs, to the definition of "covered recipients," ensuring that transfers of value to these health professionals would be made public as well.

AAPA supports the addition of PAs and other health professionals to the definition of "covered recipient." We have long advocated for increased transparency to support more informed decision-making processes. Enhanced transparency of financial relationships, when reasonably implemented, helps maintain the integrity of care and provides useful information to both beneficiaries and researchers.

However, AAPA encourages CMS to ensure the greatest level of accuracy possible for any public information released by correctly matching expenses to the appropriate health professional. With some states imposing strict penalties on health professionals who receive amounts over a certain value threshold from industry, inaccuracies in attribution may lead to unwarranted punishment for practitioners. AAPA further requests that CMS not include honoraria for being a CME presenter in such tallies as to not detract quality speakers from helping educate health professionals. The ACCME Standards for Commercial Support, which AAPA has adopted and applies in its accreditation processes, explicitly ensures manufacturers do not "…require, instruct, direct, or otherwise cause the continuing education event provider to provide the payment or other transfer of value in whole or in part to a covered recipient…" and therefore transfers of value related to accredited CME should remain exempt from reporting. Including these transfers of value in public reporting, even when done entirely accurately, will deter some of the most qualified faculty from participating in accredited CME. Finally,

AAPA suggests that CMS include proper context with the release of public information, emphasizing that any information in the data release does not necessarily imply health professionals are involved in wrongdoing.

AAPA supports the inclusion of PAs under the definition of "covered recipient." CMS should be mindful of the importance of accuracy of attribution, exclude honoraria for CME presenters, and provide proper context that public data on transfers of value does not necessarily imply wrongdoing.

Changes to the Quality Payment Program (QPP)

A Measured Approach to Program Advancement

In the proposed rule, CMS has chosen to generally maintain the framework for the 2020 QPP performance year that was laid out in the 2019 fee schedule. Minor updates were made to the Merit-based Incentive Payment System (MIPS) program in the 2020 PFS proposed rule primarily in the form of increased performance, data completeness and participation thresholds. AAPA appreciates CMS' raised submission and outcomes expectations as it continues the progression toward meaningful value-based reimbursement. By its own admission, CMS found that flexibilities permitted to encourage health professionals to participate in the MIPS program resulted in less robust data for patient decision making and practice improvement, as a large percentage of the participating population were able to meet CMS' performance thresholds. The elevation by CMS of its requirements for success under MIPS, in conjunction with the removal of low-bar quality measures, will ensure successful achievement of a positive adjustment will return increased reimbursement for those able to meet CMS' stated thresholds and ideally provide more informative and actionable data.

CMS also proposes to adjust the weights of the MIPS quality and cost categories to gradually align the emphasis of both scores. To further quell concerns over cost categories, CMS proposes to refine cost measure attribution to better assign specific costs to the appropriate professionals. AAPA appreciates CMS' attention to this concern to ensure that category measurements and scores are accurate and meaningful.

Continued Flexibility for PAs and NPs Under the MIPS Promoting Interoperability Category

CMS informs that it again plans to provide flexibility for PAs and NPs under the MIPS Promoting Interoperability (PI) category. Specifically, as a result of CMS' uncertainty as to whether PAs and NPs have the appropriate knowledge and familiarity with electronic health records (EHRs) to participate, reporting for these health professionals will be optional, with an automatic reassignment of score weight to one of the other three categories. AAPA understands CMS' intention and appreciates the continued flexibility, up until this point, as it sought to further assess PA and NP EHR capabilities. However, we suggest the expectation now be that PAs and NPs participate fully under PI, with possible exceptions for small PA- and NP-owned practices that are unable to afford EHR systems that are compliant with current requirements. PAs in most practice settings have been using EHR technology for

years, sometimes leading EHR system implementation, and should be held to the same standards and expectations as physicians.

MIPS Value Pathways (MVPs)

In addition to CMS' decision to largely maintain the current MIPS structure for the 2020 performance year, the agency solicited feedback on a potential change to MIPS reporting in upcoming years that may significantly modify the future of the program: the MIPS Value Pathways (MVPs).

CMS envisions MVPs as a new way to participate in the MIPS program beginning with the 2021 MIPS performance period. In an effort to move away from a system in which health professionals and groups choose what to report from a large set of measures that are not comparable, CMS proposes to create a method of reporting in which a health professional or group selects a pathway, structured around a specialty or condition, that best aligns with the type of care typically provided. These pathways would be built on a base of unified administrative claims-based population health and care coordination measures and would be supplemented with measures that reflect activities one would perform under the chosen specialty/condition. Measures reported under an MVP would be similar to those reported by other health professionals who have also chosen that same pathway, increasing comparability of performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and allow for quicker administrative and clinical feedback to aid in the improvement of care. CMS further believes these changes will help remove barriers to APM participation and accelerate the transition to value-based care.

AAPA approves of CMS efforts to reduce complexity of the MIPS program and enhance comparability. We caution that CMS' efforts at comparability remain encumbered by billing provisions like "incident to" that obscure the 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 hence inaccurate. While CMS has developed a way 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 brought about by the "incident to" billing method.

To enhance comparability, AAPA also suggests limiting the number of MVP pathways by not breaking up specialties into multiple MVPs any more than is necessary to ensure adequate representation through the questions in an MVP measure set. AAPA also recommends that CMS align the currently disparate benchmarks (e.g. number of measures required to report) that are based on the method one uses to report data. Finally, AAPA recommends that variation within pathways be limited to allow for a more direct comparison of health professionals with other clinicians in a similar specialty.

A question to which CMS explicitly requested feedback was regarding how the agency could determine MVP assignment. CMS indicated it is considering various methods to assign an individual or group to a specific MVP, including looking at the specialty reported by a health professional on a Part B claim, or by

drawing necessary information from PECOS enrollment data. However, these methods are concerning to PAs, who are viewed by Medicare only as the specialty "physician assistant," and not the actual specialty in which they practice. If PAs are not assigned to a specialty-specific pathway that reflects their practice, as opposed to their provider type, we are concerned they may be excluded from participation in MVPs and be required to report under the current process, which, by CMS' own admission, is more complex and less beneficial. Any method CMS might use to assign a specialty is prone to error and has the potential for increased administrative burden if practitioners appeal CMS' specialty assignment. AAPA, instead, recommends specialty self-selection with attestation for PAs. Health professionals are incentivized to choose properly since, if they do not, their ability to score well on specialty-specific measures will be compromised and would negatively affect their score and reimbursement.

AAPA notes that CMS' target date for implementation of MVPs is just over a year away. Between then and now there is only one physician fee schedule in which CMS can provide details on this significant shift in MIPS reporting and request public feedback. AAPA encourages CMS to find additional opportunities to solicit feedback on the specifics of MVP implementation over the next year. Such opportunities may include proposed rules separate from the physician fee schedule, requests for information, webinars, listening sessions, and meetings with affected stakeholders.

AAPA encourages CMS 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 as a result of their practice in multiple specialties and the manner by which they are identified as a specialty unto themselves by the Medicare program. 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 of them. In addition, measures must be able to adequately capture various roles and responsibilities that may be filled by different health professionals on a 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 will be expected to report must be consulted. The more accurate that CMS can capture the contribution of health professionals like PAs and NPs through appropriately worded measures, the more successful CMS' goal of enhanced comparability will be. CMS states in the proposed rule that it plans to work with clinician professional organizations on implementation details and we offer our assistance in any way the agency would find helpful.

In the search for specific measures that cross current MIPS categories, or that can produce meaningful data, AAPA suggests CMS draw on its past experiences with MIPS. Many qualified measures may already exist in CMS' large measure set. CMS may find it particularly useful to review existing specialty measure sets for pathway guidance. However, AAPA recommends that before any specific measures are selected and assigned, there be a public request for the identification of measures that meet the goals set forth by CMS for MVPs.

AAPA recognizes there may be some variation in the level of measurement requested, as well as the number of measures used, between the specialties/conditions in the various MVPs. We understand this

variation may be necessary to accurately and adequately capture successful practice in the various specialties/conditions. However, AAPA warns against significant variation in requirements and burden from one MVP to another so as not to create a disparity across specialty types. CMS must be mindful of the potential burdens placed on small and rural practices as measures are developed. We recommend that CMS hold discussions with health professionals in these particular practice settings to determine which solutions may best alleviate burden while maintaining CMS' ability to capture useful data.

AAPA cautions that the scope of this change and the short timeframe to potential implementation necessitate sufficient education to relevant stakeholders. Efforts to educate those affected will also require adequate time for review, analysis, and provision of feedback. AAPA suggests that 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. Another method to reduce potential confusion of MVPs is to maintain as many components from the current system as possible, as long as those components don't create additional burdens or confusion.

Another question to which CMS explicitly requested feedback was regarding how multi-specialty groups may be incorporated into MVPs. AAPA would find it unacceptable to expect a multi-specialty group to either aggregate their specialty data or ignore a subset of health professionals within a group in order to fit into one pathway. This would compromise comparability on the individual practitioner level and impair opportunities for meaningful improvement of a sub-specialty within a group. CMS lays out multiple possibilities for the participation of multi-specialty groups, including that various sub-specialties in a group independently report on different MVPs and receive separate adjustment, or that various sub-specialties report through multiple MVPs and their score is then aggregated in a fashion to be determined as one score for the entire group for reimbursement. CMS indicates the method of a multi-specialty group reporting on multiple MVPs then aggregating may be less burdensome. AAPA could be supportive of this, dependent on the details of combination for a final score and whether feedback would be provided at the pathway level so sub-specialties could receive tailored feedback.

AAPA supports CMS' measured approach to advancing the QPP program. CMS should begin to expect PAs and NPs to participate fully under the MIPS Performing Interoperability category with possible exceptions for small PA- and NP-owned practices that are unable to afford EHR systems that are compliant with current requirements. In order to improve the value of QPP data, CMS should take necessary steps to rectify the problem of data accuracy by addressing the complications brought about by the "incident to" billing method which attributes the medical services delivered by PA under the name of a physician. For optimal comparability, CMS should 1) limit the number of MVP pathways by not breaking up specialties into an excessive number of MVPs; 2) attempt to align requirements based on data submission method, and 3) limit variation of reporting requirements between health professionals using the same MVPs. CMS should provide more opportunities to comment on the details of MVP implementation, reaching out specifically to various affected health professional

stakeholder groups in various practice settings. CMS should choose measures for the MVPs both by reviewing current effective measures, as well as by soliciting measure ideas from the public and other stakeholders. CMS should ensure a robust education campaign on MVPs prior to implementation. Regarding multi-specialty groups and MVPs, CMS should allow for sub-specialties to report under different MVPs to allow for distinct assessment and feedback by subspecialty and should release ideas it may have for aggregation for reimbursement purposes sufficiently in advance for public comment. Finally, CMS should allow PAs to self-select into an MVP based upon the specialty in which they practice.

Global Surgical Packages

Congressionally mandated language in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to develop a process to gather information needed to determine the value of surgical services and components of the global surgical package. For accurate valuation of surgical services with global periods, Medicare required select practitioners in certain states to report on the number of post-operative visits following high-volume or high-cost procedures beginning July 1, 2017. The RAND Corporation published a report that summarized the current frequency of post-operative visits and described how CMS might use new claims-based data on the number of post-operative visits to adjust the valuation for surgical procedures with 10- and 90-day global periods. A recommendation made in the RAND report proposed that certain surgical procedures' global payments be lowered to reflect the actual number of post-operative visits being provided as opposed to the higher number of visits currently assigned to them. CMS has indicated they will continue to study the issue and consider ways to address appropriate global package reimbursement for 10- and 90-day surgical services.

AAPA understands the importance of determining appropriate levels of reimbursement for global surgical packages, but we stress any future modifications to the reimbursement methodology not be implemented until a thoughtful and complete consideration of possible unintended consequences is undertaken. For example, a previous CMS proposal to separate the post-operative payment from the global surgical bundle was considered. This idea was potentially problematic in that there could have been an unfair lowering of the reimbursement made for first assisting services provided by PAs, NPs and physicians, which is paid at a percentage of the global surgical package. This reduction in first assisting reimbursement would have occurred despite the fact the professional work involved in performing the first assist duties had not changed.

There are other concerns about the method of collecting information for this study. The Rand study looked at surgical procedures being performed in nine states. It is unclear if those nine selected states are typical of surgical practice in the rest of the country. A survey that encompasses additional states may be necessary to ensure data accuracy and completeness.

We are also concerned that Medicare beneficiaries might be subject to post-operative office visit deductibles and/or co-pays if the global surgical package were unbundled. Patients could be subject to hundreds of dollars of additional expenses they are not required to pay under the current system.

Equally concerning is the possibility that patients, in order to save money, would not access post-operative care services in a timely manner. The result of such delays in patients seeking care could be untreated medical complications resulting in increased severity of illness and higher costs of care.

AAPA approves of a continued search for payment validity and fairness in reimbursing for surgical services. It is recommended that CMS consider fair-minded compensation strategies that do not have unintended consequences such as a reduction in payment and/or RVUs for clinicians providing surgical assistance.

Modifications to Evaluation and Management Reimbursement and Documentation

CMS again proposes significant changes to the methodology in which office-based evaluation and management (E/M) visits are reimbursed, as well as to Medicare requirements for medical record documentation for those same visits. In AAPA's comments to the 2019 PFS proposed rule, we supported CMS making coding, payment, and documentation changes for office-based E/M visits that would reduce administrative burden, improve payment accuracy, and better reflect the current practice of medicine. However, we also expressed serious concerns about CMS' proposed single payment rate for level 2-4 outpatient office E/M visits that were scheduled to go into effect in 2021.

AAPA supports the revised proposal that would maintain separate payment for the levels of office-based E/M visit Current Procedural Terminology (CPT) codes, as recommended by the CPT Editorial Panel. In particular, AAPA agrees with having four codes available for new patient encounters (99202–99205) and five codes for encounters with established patients (99211-99215). We also agree with eliminating history and examination as documentation components for selection of the appropriate level of office visit, and instead relying on complexity of medical decision-making or the total time spent by the reporting practitioner during the visit.

These proposed changes to medical record documentation requirements represent a substantial transformation from existing documentation guidelines. If finalized, it is important for CMS to inform health professionals and their billing and coding personnel about the change and provide sufficient educational material prior to the January 2021 implementation date.

AAPA agrees with CMS' proposals to maintain separate payment for each level of office/outpatient E/M visits and eliminate history and examination as components for selection of the level of office visit, instead relying on complexity of medical decision-making or the total time personally spent by the reporting clinician to determine the appropriate CPT code.

Principal Care Management

CMS has found positive results when Chronic Care Management (CCM) is used by health professionals, both through financial savings and in patient/provider satisfaction. However, CMS notes that CCM

remains underutilized. This may, in part, be because current CCM codes require patients to have two or more chronic conditions to qualify for the service. AAPA has always viewed this requirement as overly restrictive as there can be benefits from similar care coordination for patients with one complex or high-risk condition. To expand the benefit seen from CCM, CMS is proposing to implement similar but separate codes and payment for patients with one serious condition: Principal Care Management (PCM). Specifically, CMS proposes to make separate payment for PCM via two new G codes: HCPCS code GPPP1 and GPPP2.

AAPA commends the agency for continuing to recognize the additional care provided to complex patients that extends beyond a typical face-to-face encounter. We interpret the development of PCM as CMS' recognition that it is not solely the number of conditions a patient has but also the severity, and that one condition can be severe enough to benefit from provider care management and care coordination. AAPA would support efforts to prevent duplication of services and care fragmentation by requiring regular communication between health professionals treating the same patient. AAPA also supports extending the same requirement that exists under CCM, to receive patient consent, to PCM. Patients should be permitted to make their own decisions as to whether care management is worth potential increased cost sharing, but CMS should release relevant findings regarding the benefits of coordinated care found under CCM to support health professionals in informing patients of the benefits of care coordination. Finally, PAs, like other qualified health professionals, have the training and scope of practice to manage chronic and complex medical conditions and coordinate related care. For Medicare beneficiaries to receive the benefit of PCM, AAPA encourages that CMS policy in the Final Rule clearly indicate that PAs, as qualified health professionals, are eligible to provide, direct, and be reimbursed for care provided as PCM services.

AAPA supports the creation of PCM codes, requirements to maintain coordination of patient care, and requirements to receive patient permission. CMS should develop material on the benefits of coordination to be shared with beneficiaries making the decision. CMS should make explicit that PAs are qualified to provide, direct, and be reimbursed for PCM services.

Thank you for the opportunity to provide feedback on the 2020 Physician Fee Schedule proposed rule. AAPA welcomes further discussion with CMS regarding our position 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,

David E. Mittman, PA, DFAAPA
President and Chair of the Board