January 17, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Centers for Medicare and Medicaid Services (CMS)

Sent via email to: PatientsOverPaperwork@cms.hhs.gov

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 140,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments in response to The Centers for Medicare and Medicaid Services' (CMS) request for feedback on eliminating unnecessary and burdensome scope of practice requirements for PAs under the Medicare program. We applaud Section 5 of the President's Executive Order (#13890) entitled *Protecting and Improving Medicare for our Nation's Seniors*. As our healthcare system continues to evolve, we must continue to modernize Medicare regulations to remove outdated barriers to practice that restrict patient access to high-quality healthcare. We strongly agree with the recent Executive Order that regulations should be updated and changed to remove these outdated barriers, ensuring all healthcare professionals are practicing at the top of their license.

We appreciate the progress CMS has already made in removing Medicare barriers to PA practice through the Patients Over Paperwork initiative. We would like to express our appreciation for recent policy changes adopted by CMS that have enhanced care efficiency and flexibility. These changes include CMS authorizing PAs to act in the capacity of the required primary care provider on Programs of All-Inclusive Care for the Elderly (PACE) interdisciplinary team; the removal of requirements for a physician visit in order to be assigned to an Accountable Care Organization if a beneficiary voluntarily identifies a PA as the clinician they want to coordinate their care; changing the term "licensed independent practitioner" to "licensed practitioner" to clarify how PAs function in hospitals and changes authorizing PAs to write progress notes in psychiatric hospitals.

Following the significant progress that has occurred, additional burden reductions measures were finalized in the 2020 Physician Fee Schedule final rule including Medicare's definition of the PA relationship to physicians and other members of the team being determined by state law; expansion of a PA's ability to serve as the patient's "attending physician" for hospice care and clarification of a PA's ability to serve as a teaching preceptor and to have the documentation of students be used on the preceptor's medical record that is submitted to Medicare for billing purposes.

As the agency moves forward on its regulatory relief initiatives it should be noted statutory language in Subsection (K)(i) of the Social Security Act [Section 1861 (42 U.S.C. 1395x)] authorizes PAs to perform services that would be physician services if furnished by a physician. That overarching language suggests any authorized medical service physicians provide to Medicare beneficiaries, that is within a PA's state

scope of practice, should be covered and authorized when provided by a PA. CMS should use this guiding authority to remove many if not all unnecessary barriers to PAs delivering care to Medicare beneficiaries.

Per CMS' request we are providing examples of other Medicare policies that increase administrative burdens, disrupt continuity of care for our patients, hinder the Medicare program's data analysis by allowing for the collection of inaccurate information, and reduce patient access to care - especially in rural and underserved communities. We encourage CMS to pursue the following policy changes to ensure beneficiary access to care including:

- Authorizing PAs to receive direct payment under Medicare;
- Authorizing PAs to order, certify and recertify their patients' need for home healthcare;
- Authorizing PAs to order and supervise cardiac and pulmonary rehabilitation;
- Authorizing PAs to certify their patients' need for therapeutic shoes for treatment of their diabetes;
- Authorizing PAs to certify terminal illness and certify/recertify the need for hospice care.

We have also identified problematic Medicare provisions that likely only need an updated clarification as opposed to a policy or regulatory change. Barriers that fall into that category include:

- Updating the Medicare state operations manual to align with the CMS stated policy that does not require a physician co-signature when a PA discharges a beneficiary from the hospital;
- Clarifying that a PA is authorized to admit a patient to the hospital without the requirement of a physician co-signature;
- Authorizing PAs to perform assessments in Inpatient Rehabilitation Facilities.

We request that CMS continue in its efforts to implement the intent of Section 5 of the Executive Order by revising policy manuals, appropriately interpreting existing regulations or utilizing the rulemaking process to ensure the ability of PAs to deliver patient care to the full extent of their education and experience. We are also enclosing a list of Medicare regulatory burdens detailing both the problem and a proposed solution.

Thank you for your consideration of these comments and the agency's ongoing commitment to removing barriers to practice for PAs and the patients we serve. For any questions you may have 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

cc: The Honorable Alex M. Azar II, Secretary
United States Department of Health and Human Services

January 14, 2020

Improving Access to Care for Medicare Beneficiaries Through Increased Choice and Competition

The American Academy of PAs (AAPA), on behalf of the more than 131,000 PAs (physician assistants) throughout the United States seeks to reduce unnecessary Medicare regulatory and administrative burdens that drive up costs and impede Medicare beneficiaries from receiving the care they need. The Medicare program authorizes PAs to deliver a wide range of medical services and PAs are committed to providing the highest quality care to all Medicare beneficiaries. To accomplish this goal, it is essential that Medicare's policies authorize PAs to practice at the top of their education and expertise. The Medicare program should continue to strive to eliminate rules or regulations that hinder the ability of patients to receive medically necessary care from PAs due to outdated or ineffective policies which do not increase care quality or lead to improved healthcare delivery cost-effectiveness.

The Centers for Medicare and Medicaid Services (CMS) has been actively working to reduce administrative burden through the Patients Over Paperwork initiative. AAPA would like to express our appreciation for recent policy changes adopted by CMS that have enhanced care efficiency and flexibility. These changes include CMS permitting PAs to act in the capacity of the required primary care provider on a Programs of All-Inclusive Care for the Elderly (PACE) interdisciplinary team; the removal of requirements for a physician visit in order to be assigned to an Accountable Care Organization if a beneficiary voluntarily identifies a PA as the clinician they want to coordinate their care; changing the term "licensed independent practitioner" to licensed practitioner to clarify how PAs function in hospitals and changes authorizing PAs to write progress notes in psychiatric hospitals.

Following the significant progress that has occurred, additional burden reductions measures were finalized in the 2020 Physician Fee Schedule final rule including Medicare's definition of the PA relationship to physicians and other members of the team being determined by state law; expansion of a PA's ability to serve as the patient's "attending physician" for hospice care and clarification of a PA's ability to serve as a teaching preceptor and to have the documentation of students be used on the preceptor's medical record that is submitted to Medicare for billing purposes.

Barriers to Care

Direct Payment

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, and others.

AAPA requests that CMS authorize PAs to receive direct payment from Medicare.

Restrictive Policies on PAs and NPs Providing Home Health Care

PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs (and NPs) for the 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 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.

AAPA suggests that CMS authorize PAs to certify, order and sign the plan of care for home health services.

Prohibition on PAs and NPs Ordering Diabetic Shoes

PAs are already authorized to order DME. 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 needs 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.

AAPA requests that CMS authorize PAs and NPs to certify the need for, and order, diabetic shoes.

Hospital Admission Co-Signature Requirements

Medicare policy permits PAs to determine the necessity of an inpatient hospital admission, write the admission order, and perform the accompanying history and physical examination. However, it has been interpreted in the past that such admission 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. We note that changes to requirements for documentation of hospital admission under the Hospital Inpatient Prospective Payment System may correct this problem. However, CMS has yet to explicitly clarify that a physician co-signature is not required when a PA admits a patient to the hospital.

CMS should clarify that when a PA makes the admission decision (order) for a hospital admission, a physician co-signature is not required.

Unnecessary Restrictions on PAs and NPs for Supervising Diagnostic Tests

PAs are authorized to request and perform diagnostic tests consistent with their state law scope of practice. However, only a physician may supervise ancillary staff performing these tests. 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 and NPs to supervise diagnostic tests will improve efficiency in the healthcare system by expanding access to care.

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

Co-Signature Prior to Hospital Discharge

Longstanding Medicare policy had indicated that 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. 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. Recently, CMS communicated to AAPA that a physician co-signature on discharge summaries is no longer required. However, manuals utilized by state surveyors still contains the co-signature requirement.

AAPA requests that CMS publicly clarify this policy and update the State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals page 292, that the co-signature requirement is no longer in effect.

Restrictions on PA and NP Practice in Skilled Nursing Facilities

For many years, PAs have been authorized to deliver care to Medicare beneficiaries in skilled nursing facilities (SNFs). However, PAs are not recognized by Medicare regulation for the 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.

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

Limitations on Care Delivery in Inpatient Rehabilitation Facilities (IRF)

At present, certain Code of Federal Regulations (CFR) sections regarding IRFs use physician-centric language when establishing care delivery requirements. For example, §412.622(a)(3)(iv) indicates a rehabilitation physician must conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality, and to modify the course of treatment as necessary. Meanwhile, §412.622(a)(4)(ii) requires a rehabilitation physician to conduct a post-admission evaluation within 24 hours of admission, and document that evaluation in the patient's medical record. However, to address a concern about regulatory burdens in IRFs, CMS has expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs and NPs to fulfill some of the requirements previously assigned only to rehabilitation physicians. AAPA fully supports CMS' proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place in rehabilitation hospitals. Allowing PAs to provide care they are educated and qualified to perform will ease both regulatory burden, as well as increase patient access due to the availability of additional health professionals.

AAPA requests that CMS make regulatory changes necessary to expanded use of PAs (and NPs) in Inpatient Rehabilitation Facilities.

A Refusal to Reimburse for Certain Required Services in PA-owned Rural Health Clinics (RHC)

Federally certified RHCs must have a PA, NP 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.

AAPA recommends that CMS establish a payment method for when PAs in RHCs are performing CMS-mandated diagnostic tests to beneficiaries.

Medicare policy is unclear regarding the ability of PAs to be covered for the interpretation of electrocardiograms (EKGs).

The interpretation of EKGs is a basic medical responsibility that fits into a PAs training, education and scope of practice. PAs deliver a wide range of professional services and there should not be unnecessary and irrational barriers to the care delivery process.

AAPA recommends that CMS clarify its policy and make it clear PAs are authorized to provide the professional interpretation for EKGs.

Discrepancies in Medicare Administrative Contractors (MAC) Policies

MACs are contracted to implement national Medicare policy at the state level. However, some MACs have created local policies that are not in alignment with national Medicare policies. Consequently, health professionals are subject to Medicare practice variability based on divergent MAC interpretations. Examples include documentation requirements for split/shared visits, co-signature requirements for "incident to" billing, and the ability of PAs to submit claims for initial hospital encounters, discharges, and certain services and procedures, such as ophthalmology services.

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

"Incident To" Billing

"Incident to" is a Medicare billing provision that allows reimbursement for services delivered by PAs and NPs at 100% of the physician fee schedule, as opposed to the typical 85%, provided certain criteria are met. When "incident to" billing is utilized, care provided by a PA is attributed to a physician with whom they work.

For patients, this has numerous detrimental effects. For example, "incident to" billing requires that a series of conditions be met to receive 100% reimbursement for PA or NP services. The fulfillment

of these conditions, which if not for the use of "incident to" would not be required, adds additional obligations for both PAs/NPs, and physicians, that may negatively affect the efficiency of care provided. This increased burden at the expense of efficiency in patient care works counter to the objectives of the Patients Over Paperwork initiative. In addition, each patient receives an Explanation of Benefits (EOB) notice after receiving care. The EOB identifies the service the patient received and who delivered the care, among other details of the visit. "Incident to" billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the EOB notice. This can cause patients to question who their actual care provider is, and whether they need to correct what appears to be erroneous information regarding their visit. Finally, use of "incident to" billing may threaten a PA's or NP's ability to be listed along with other health professionals on performance measure websites, such as Physician Compare, thus restricting a patient's awareness of available care options. If health professionals such as PAs and NPs are included on Physician Compare, but not all services are attributed to them as a result of "incident to" billing, patients, while aware of the existence of these providers, will not be able to make fully-informed comparisons between them as these health professionals are not accurately portrayed in the available data.

"Incident to" also masks the positive impact of PAs and NPs on the healthcare system. Consequently, it is nearly impossible to accurately identify the type, volume or quality of services delivered by PAs and NPs. The absence of data attributed to PAs and NPs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, will influence an employer's analysis of PA/NP contribution to the healthcare organization.

Patients and health professionals are not the only stakeholders who are disadvantaged by "incident to," as healthcare researchers and the Medicare program itself stand to suffer from inaccurate data collection. In the 2019 Physician Fee Schedule Final Rule, CMS stated that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services "incident to" a physician when furnished by an NP or PA. The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, similarly recognized the problem and unanimously voted to recommend to Congress the elimination of "incident to" for PAs and NPs.

AAPA supports MedPAC's recommendation that "incident to" billing be eliminated. However, recognizing that legislative action on this issue may take time, AAPA encourages CMS to both explicitly recognize the numerous problems that result from the current use of "incident to" billing as it relates to PAs and NPs and to publicly solicit input in a proposed rule from affected stakeholders as to how to best resolve those concerns until the billing provision is legislatively removed.

Outdated Hospice Constraints on 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 omission of PAs from being able to provide the face-to-face encounter falls short of continuity of care goals as hospice patients receiving care and care direction from PAs will be required to have another health professional, who the patient may not have interacted with, provide the face-to-face encounter. 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 that 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 (hospice physician, registered nurse, social worker, and pastoral or other counselor).

AAPA requests that CMS authorize PAs 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.

Denial of PA Claims Due to the Misinterpretation that PAs Practice in the Same Specialty

Medicare policy defines a new patient as a beneficiary who has not received any professional services from a clinician or another provider within a group practice within the same specialty in the previous three years. Because PAs all have the same specialty code (97), this has led to denials of claims when more than one PA, but in different specialties within a multi-specialty practice, sees

a patient for an initial encounter within three years. There is a similar problem when a Medicare beneficiary sees more than one PA on the same calendar day, because CMS only permits one evaluation and management (E/M) service per beneficiary per date of service for each provider specialty. The single specialty code for PAs has become more of a problem as practices consolidate into larger, multi-specialty practices. This has led to reduced payments or denials of claims for payment that would otherwise be appropriate based on the service provided.

CMS proposed (but did not enact) eliminating the prohibition on reimbursement for same-day E/M services by multiple practitioners in the same specialty. In addition, National Government Services (NGS) issued corrective action to the problem of denials caused by same-day E/M services provided by more than one PA, advising providers in their jurisdiction to continue to indicate the PA specialty of 97 while also including the specialty of the collaborating physician or group-specialty under which the PA has provided the service in the 2300 or 2400 Loop NTE Segment (or Box 19 on paper) for all claims. To date, CMS has not adopted a system-wide process for denials of E/M claims by multiple PAs in different specialties on the same day of services, NGS has reported low compliance with the proposed corrective action, and no attempts have been made to reduce denial

of claims for new patient services made by various PAs of different specialties in a multi-specialty group practice.

AAPA recommends that CMS find system-wide methods to avoid denials of claims or reduced payment for services provided by PAs in different specialties.

Exclusions on Ordering Medicaid Durable Medical Equipment (DME)

Recently, a limited number of state Medicaid agencies have been moving to restrict PAs and NPs from ordering DME for patients. This stems from the fact that those states believe there is no stand-alone federal Medicaid language that allows for PAs and NPs to order DME, as exists under Medicare. Rather, the only mention of DME in federal Medicaid regulations is under the section on home health, which has traditionally been restrictive for PAs and NPs. Some states are interpreting this to mean that the restrictive nature of home health policies now pertain to DME as well.

CMS should clarify the ability of PAs and NPs to order DME under the Medicaid program.

Inability of Patients to be Aligned with an Accountable Care Organization (ACO) Through the Claims Process When All of Their Care is Provided by a PA or NP

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 advanced practice registered nurses (APRNs) can't be automatically assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA is the only health professional in the community. Patients treated by an ACO physician are automatically attributed to the ACO through the claims process. That same process is not available to PAs and APRNs. Patients must take the extra step of going online to select a PA (or ARNP) as their ACO provider in order to be assigned to an ACO.

AAPA recommends that CMS authorize patient attribution to an ACO when a patient has received all their medical care from a PA or an NP.

PAs/NPs Are Not Authorized to Supervise Cardiac, Intensive Cardiac, Pulmonary Rehab Services until 2024. PAs/NPs Are Not Authorized to Order/Prescribe Cardiac, Intensive Cardiac or Pulmonary Rehab Services.

Studies have shown that Medicare patient outcomes are improved when they have access to cardiac and/or pulmonary rehabilitation services. Currently, only physicians are authorized to supervise and prescribe Medicare beneficiaries for cardiac and/or pulmonary rehabilitation services. When a

physician is not available, the beneficiary does not have access to these important services. Supervising these services (establishing an exercise program, counseling, education, outcomes assessment, etc.) is within the scope of practice and level of expertise of appropriately trained PAs. Legislation has passed Congress to authorize PAs to supervise cardiac and pulmonary rehab services beginning in 2024. Medicare has also interpreted "physician prescribed" exercise to mean that a patient must have a referral or order that is signed or co-signed by a physician. AAPA and other stakeholders believe that a referral/order to cardiac and pulmonary rehabilitation is different than a physician-prescribed exercise plan and is an additional barrier to Medicare patients receiving these services.

AAPA recommends that the implementation date to authorize PAs and NPs to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs be accelerated. AAPA also requests that CMS change its interpretation of physician-prescribed exercise and immediately authorize PAs and NPs to refer eligible Medicare beneficiaries to these rehabilitation services.

PAs/NPs are Not Authorized to Receive the Ten Percent Bonus Payment When Delivering Care in Health Professional Shortage Areas (HPSAs)

To attract more physicians to underserved communities physicians are entitled to a ten percent bonus payment when delivering care in HPSAs. That same bonus does not apply to PAs and NPs thereby creating a barrier to attract PAs to these underserved communities.

AAPA recommends that PAs and NPs be authorized to receive the ten percent bonus payment when delivering care in HPSAs.

Exclusions on PAs Providing Medical Nutrition Therapy (MNT)

PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. Currently, however, only physicians are authorized to order MNT service. 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. AAPA suggests that CMS request Congress change the statute to authorize PAs to order MNT.

AAPA suggests that CMS authorize PAs to order Medical Nutrition Therapy.

Restriction of Mammography Interpretation to a Physician

Despite being competent to interpret mammography, Medicare policy limits such interpretation to a physician. This restriction means that patients treated by a PA can't have their care fully provided by PAs.

AAPA recommends that PAs be authorized to interpret screening mammography.

Restrictions on PAs Interpreting Bone Mass Measurement Results

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 healthcare costs, and disability.

AAPA recommends that PAs be authorized to interpret bone mass measurements.

AAPA welcomes further discussion with CMS regarding these issues. For any questions you may have please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319- 4345 or michael@aapa.org.