October 3, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-5519-P
200 Independence Ave., SW
Washington, DC 20201

RE: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)

Dear Administrator Slavitt,

The American Academy of PAs (AAPA), on behalf of the more than 108,500 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the *Medicare Program; Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)* proposed rule. PAs provide care under the Medicare program in all 50 states and the District of Columbia, in many different specialties and practice settings, and under many different reimbursement systems. Consequently, PAs have a vested interest in the models of care the Center for Medicare and Medicaid Innovation (CMMI) establish.

AAPA is a proponent of CMMI's efforts to develop new and forward-thinking models of healthcare delivery for implementation, examination and analysis. CMMI uses these models similar to pilot programs to test the effectiveness and efficiency of various care delivery and payment approaches. CMMI then identifies and promotes the best practice care and delivery models that have proven successful, such as was done with the Diabetes Prevention Program Model. CMMI's efforts, and the various models it tests and implements, are comparable to the concept of using states as laboratories to explore care models and policies for consideration and potential replication.

Section 42 Code of Federal Regulations (CFR) 410.49, which provides conditions of coverage for the cardiac rehabilitation (CR) program and intensive cardiac rehabilitation (ICR) program, details the functions of a supervising physician under the programs, indicates that exercise is prescribed by a

physician under the programs, and asserts that individualized treatment plans under the programs are established/reviewed/ signed by a physician. CMS' proposed rule would waive the definition of 'physician' to include non-physician practitioners under section 42 CFR 512.630 for CR and ICR services provided to an Episode Payment Model beneficiary during an acute myocardial infarction or coronary artery bypass graft episode of care. The rule explicitly identifies the inclusion of PAs, as well as nurse practitioners (NPs) and clinical nurse specialists (CNSs). As noted in the proposed rule, the allowance of other health professionals, such as PAs, to perform these previously physician-exclusive CR and ICR activities increases both program flexibility and availability of CR and ICR services for patients.

AAPA finds particular value in delivery models that seek to expand care options for patients, improve patient outcomes and recognize the ability of health professionals to practice to the full extent of their education, expertise and experience. As a national physician shortage continues to worsen, health professionals who are qualified to oversee activities and treatments previously reserved only for physicians will help fill the gap and improve access to care for Medicare beneficiaries. It is for these reasons that AAPA expresses its strong support for the waiver provision of the proposed rule that expands patient access to CR and ICR services by authorizing PAs to provide these services under the programs.

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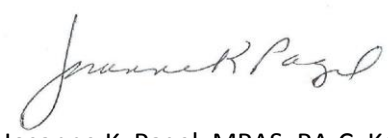
One issue of concern is that the proposed rule explicitly excludes the role of Medical Director from the waiver, preventing PAs and advanced practice nurses from serving in that capacity. The current definition of a CR and ICR program Medical Director, as defined in CFR 410.49(a), is a physician who oversees or supervises the CR and ICR programs at a particular site. Rather than employing an across-the-board policy that only a physician is able to fill this role, we encourage CMMI to allow health professionals that are qualified to discharge the duties and responsibilities of a medical director of these programs to act in this capacity. True innovation in the delivery of health services calls for removing historic barriers and taking an unbiased look at how best to make timely, quality care available to those beneficiaries who can benefit from that care. Medical skill sets, competence and experience should determine who is able to accept the role of medical director. Authorizing appropriately qualified PAs to serve as the medical director in CR and ICR programs would be particularly beneficial in rural communities where there are fewer available physicians.

AAPA recommends that the waiver extend the role of Medical Director to qualified PAs in cardiac and intensive cardiac rehabilitation programs.

AAPA appreciates this opportunity to provide feedback on the proposed wavier for CR and ICR and welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. 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,



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