September 13, 2021

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 151,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Center for Medicare and Medicaid Services' (CMS) proposed 2022 Payment Policies Under the Physician Fee Schedule rule. PAs are committed to increasing access to high quality care for all Medicare beneficiaries and we seek to work in partnership with CMS in the advancement of healthcare policies that help in achieving that goal. PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies made in the Physician Fee Schedule, the Quality Payment Program, and other aspects of the proposed rule. PAs will have an increasingly important role in the US healthcare delivery system and currently provide hundreds of million patient visits each year. Many of those visits are from Medicare beneficiaries. It is within this context that we draw your attention to our comments.

PA (Physician Assistant) Direct Payment

The agency proposes to implement provisions set forth in Section 403 of the Consolidated Appropriations Act (CAA) of 2021 to remove the requirement that the Medicare program make payment for PA services only to the employer of a PA. With the removal of this constraint, effective January 1, 2022, PAs will be authorized to receive direct payment under the PA's name for services provided to Medicare beneficiaries. This change will also authorize PAs to reassign payment for their services and have the opportunity, if desired, to form a state-approved solo corporation or a state-approved corporation comprised solely of PAs that bills the Medicare program in the same manner as physicians, nurse practitioners, and other health care professionals.

AAPA worked with Congress to include legislative language in the CAA of 2021 to authorize PA direct payment. As such, we fully support the agency's implementation of this provision through the proposed 2022 Physician Fee Schedule rule. In addition, AAPA supports the fairness of PAs having parity in payment methodology with other health professionals. Direct payment will authorize PAs to expand the types of care they provide to beneficiaries as they participate in innovative care models and practice in non-traditional

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employment arrangements. In the early years of the PA profession, when a PA was employed by a single physician or small physician group, Medicare payment to the PA's employer was an effective arrangement. Health care delivery has and continues to undergo a rapid transformation. In today's health care environment of integrated delivery systems and newly developed models of care, PAs practice medicine and deliver medical and surgical services in a variety of employment and practice arrangements. The COVID-19 pandemic and the ensuing Public Health Emergency demonstrate the importance of ensuring maximum flexibility in the deployment and utilization of all health professionals to improve health outcomes for patients. This policy change will improve the ability of PAs to help meet the changing needs of the US health care system.

Also, it is essential that Medicare Administrative Contractors (MACs) throughout the country be appropriately educated regarding this policy change and be required to update their internal processes, websites, and public facing informational sources to prevent confusion and delayed implementation of the PA direct payment provision at the state/local practice level. CMS proposes to remove from language from the Code of Federal Regulations (CFR) that "A qualified employer is not a group of physician assistants that incorporate to bill for their services." AAPA encourages the agency to specifically communicate with MACS that as of January 1, 2022, there is no prohibition against the enrollment of, and payment to, a group of PAs or a solo PA who owned a state-approved corporation. **We encourage CMS to update the necessary CFRs, Medicare claims processing manuals and guidelines, Medicare's Internet Only Manual, Medicare Learning Network publications, CMS 855 enrollment application(s), and other material by January 1, 2022, to ensure a seamless transition to this new policy.**

Hospice Care and Employment Status

CMS recommends removing certain restrictions on the employment status of hospice attending physicians. Currently, PAs, physicians, and nurse practitioners (NPs) employed by or under contract with a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) are unable to act in the capacity of a hospice attending physician during the time they are working in an RHC or FQHC. If an RHC or FQHC-employed PA, physician or NP chose to provide hospice attending physician services, it was required that those hospice services be delivered outside of their hours worked at the RHC or FQHC, not conflict with an employment agreement, and not violate Medicare prohibitions on comingling.

In the proposed rule, CMS is implementing Section 132 of the Consolidated Appropriations Act of 2021 that would allow both RHCs and FQHCs to receive payment for hospice attending physician services. Consequently, this would remove restrictions on RHC- or FQHC-employed or contracted PAs, physicians and NPs providing hospice attending physician services while working at the RHC or FQHC, and these centers would be authorized to receive payment for such services under the RHC AIR and FQHC PPS, respectively.

AAPA supports this change in policy as it would remove an unnecessary barrier to the efficient provision of hospice care for Medicare beneficiaries. Studies and reports continue to demonstrate that in general, rural Americans are older and sicker, and have increased health disparities, as compared to their urban counterparts. Although growing, Medicare hospice use is lower for rural than urban beneficiaries. Difficulty in recruiting hospice health professionals and longer drive times to reach patient's homes in less densely populated areas are two of the unique challenges of delivering hospice care in rural communities.

Authorizing hospice attending physicians who work in RHCs and FQHCs to more efficiently provide hospice care will help improve the delivery of hospice services.

While CMS has formalized several policies in the past few years with the goal of increasing access to hospice care, a number of impediments to efficient care delivery for hospice patients remain. Some of these impediments, much like the provision CMS proposes to change in the 2022 Physician Fee Schedule proposed rule, also involve unnecessary restrictions on hospice care provision due to an otherwise qualified health professional's site of employment.

Federal legislation (the Medicare Patient Access to Hospice Act as part of the Bipartisan Budget Act of 2018), and subsequent CMS regulations, broadened the Medicare definition of hospice "attending physician" to include PAs as of January 1, 2019. The law and regulations that led to this policy change were widely seen as granting PAs the ability to provide nearly all services an NP could under hospice. However, CMS indicated that while PAs are authorized to act in the role of an attending physician, due to continued language in the Hospice Conditions of Participation (42 CFR 418.106(b)), PAs were unable to order medications for hospice patients. This policy severely constrained PAs from fully functioning in their new role and hindered access to hospice services for vulnerable patients.

As a result, in the 2020 Physician Fee Schedule final rule, CMS sought to partially remedy this issue by amending the CFR to permit PAs who were acting as attending physicians, and who were not employed by the hospice, to order medications for hospice patients. These limitations preventing a hospice-employed PA from prescribing do not apply to physicians and NPs. 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.

CMS previously indicated that 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 Conditions of Participation (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)[1] of the Social Security Act to provide nursing services as part of a hospice benefit. There is similar mention in this section of "physicians' services", which, according to Chapter 15[2] 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, who are authorized to provide care as part of the interdisciplinary group, should be permitted to prescribe under a similar authority that granted NPs the ability.

The exclusion of PAs from this interpretation of Section 1861(dd) has likely contributed to another obstacle to patient-centric care. In Chapter 9[3] of the Medicare Benefits Policy Manual, it is noted that if a beneficiary has not selected an attending physician at time of terminal illness, the hospice beneficiary is given the choice of being cared for by either a physician or NP who works for the hospice. In other words, PAs may hold the status of hospice attending physicians, but are not granted the ability to act as a substitute for the same role in the absence of a patient pre-selected attending physician. AAPA finds this disconnect illogical and

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[1] https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
[3] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

restrictive of patient choice. AAPA requests further information regarding CMS' determination that PAs are capable of serving in the role of an attending physician but are unable to do so when employed by a hospice and the patient has not previously selected an attending physician. This artificial distinction between the role of PAs and NPs in hospice care is not based on clinical skill set, quality of care or patient care outcomes.

AAPA appreciates CMS efforts both in the 2022 Physician Fee Schedule proposed rule and in prior years to ensure minimal disruption in a patient's access to needed hospice services. Hospice patients are often at the most vulnerable state of their lives when electing hospice coverage and should not face cumbersome or excessive policy obstacles to essential care. Consequently, considering the examples we have stated above regarding continuing hurdles for hospice patients receiving timely access to care, and to enhance patient choice in care options, AAPA recommends the following:

- **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 and so it is essential that 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.

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

Meanwhile, AAPA continues to note other outdated constraints on the provision of hospice care to patients. 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 the health professional 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. These restrictions apply to NPs as well.

PAs should be authorized to certify terminal illness. Assessing terminal illness is a clinical judgement based on knowledge of a patient and their disease state. PAs are trained in the medical model and capable of diagnosing and making independent medical determination of severity and course of illness. Section 1814(7)(A) of the Social Security Act[4] authorizes two parties to certify terminal illness: a medical director, and an attending physician (but excluding PA and NP attending physicians). By including an attending physician as one of the two groups that can certify terminal illness, we believe the determination of life

[4] https://www.ssa.gov/OP_Home/ssact/title18/1814.htm

expectancy should be able to be made by a trained and qualified health professional who best knows the patient and the patient's medical history and prognosis. The explicit exclusion of PAs and NPs should be removed. AAPA believes the continued existence of these restrictions may negatively affect the experience of hospice patients.

In addition, AAPA requests that CMS work with Congress to the increase in efficiency of the Medicare hospice program that would result from authorizing PAs to:

- **Certify and recertify terminal illness**
- **Admit a patient to hospice**
- **Act in the capacity of a required member on an interdisciplinary group in place of a physician**
- **Perform any required face-to-face encounters.**

Direct Supervision

Direct supervision is the level of supervision Medicare requires for "incident to" billing, some diagnostic tests, and certain other services. During the public health emergency, CMS indicated through IFC 1744[5] that direct supervision requirements could be met by the supervising clinician being available via audio/visual (interactive) communication. This flexibility was granted to minimize the transmission of COVID-19, meet the increased needs of patients, facilitate the utilization of telehealth, and mitigate the risk of patients not receiving timely medical care.

In the 2022 Physician Fee Schedule proposed rule, CMS is seeking input on whether the ability to use audio/visual communication to meet the requirements of direct supervision should be made permanent for all services for which direct supervision is required, whether the flexibility could be made permanent for only some services, or, if authorization for virtual direct supervision should be allowed to expire, what the timeline for sunsetting the flexibility should be.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 Public Health Emergency. We recognized that this flexibility was necessary to minimize exposure to COVID-19 and reduce detrimental impacts of the pandemic on the timely provision of care. While we had formerly requested that the agency make this provision permanent, AAPA is no longer in support of a blanket use of audio/visual communication to meet direct supervision requirements. Our concern is due to the negative effects that will result related to transparency. As noted in our previous comments, despite requesting permanent authorization of audio/visual communication to meet direct payment requirements, we were concerned regarding the impact on transparency. These concerns remain and now incline us to recommend that CMS only authorize audio/visual direct supervision in certain circumstances.

AAPA continues to have significant concerns regarding "incident to" billing for services provided by PAs/APRNS and the transparency complications that come with it. As you are aware, "incident to" is a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of

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[5] https://www.cms.gov/files/document/covid-final-ifc.pdf

another health professional. Of particular interest to us is “incident to” billing pertaining to services performed by PAs and APRNs that are attributed to a physician. Due to the manner services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services delivered to Medicare beneficiaries by PAs and APRNs may be attributed to physicians. When this occurs, it is nearly impossible to accurately identify the type, volume or quality of medical services delivered by PAs and APRNs. Accurate data collection and appropriate analysis of workforce utilization is lost. This lack of transparency has a negative impact on patients, health policy researchers, the Medicare program, and PAs/APRNs.

One of the key issues in ensuring that healthcare is consumer-centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB) notice after receiving care. The MSN/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 MSN/EOB notice. When PA services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who was not seen by the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Physician Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals with an assessment of the professional’s overall quality of care based on a Medicare computed performance score. When services performed by PAs are hidden due to “incident to” billing, not only is Medicare unable to determine PA quality scores, but these scores may not appear on the Physician Compare site if the health professional does not exceed the low-volume threshold as a result of fewer services attributed to them. In addition, if PAs have all their services billed under “incident to,” those PAs may not appear on the Physician Compare website. PAs not being identified on Physician Compare, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a healthcare provider.

With a substantial number of services provided by PAs and APRNs attributed to physicians in “incident to” billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research performed using such data are similarly biased by a lack of attribution to the PA or APRN who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distort the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies. Under “incident to” billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care and resource use allocation.

The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and APRNs in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and APRNs was billed “incident to,” and identified many of the adverse

consequences of "incident to" billing stemming from compromised data quality.[6] Similarly, in CMS' recent 2019 Physician Fee Schedule final rule, the agency acknowledged 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 a PA or NP.[7] The absence of data attributed to PAs and APRNs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program, and threatens their ability to be listed along with other health professionals on performance measure websites, such as Physician Compare. Similar concern regarding the negative impact of "incident to" billing on the accuracy and validity of value-based programs has been echoed in a Health Affairs Blog in a January 8, 2018, posting.[8] While claims reimbursement is by no means the only measure of a health professional's value and productivity, it is an essential component. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, can influence the analysis of PA/APRN healthcare contributions.

AAPA is concerned that CMS authorizing a blanket fulfillment of direct supervision requirements by audio/visual communication would only make it easier to use "incident to" billing, thereby leading to expanded use of the billing mechanism. This would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional.

Consequently, due to our ongoing concerns with "incident to" billing and its harm to transparency, AAPA instead suggests that direct supervision by audio/visual communication be extended beyond the end of the public health emergency only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for these health professionals, such as registered nurses, medical assistants and technicians, will find benefit in expanded patient access to care as it will increase flexibility in supervisory requirements for such professionals to perform their duties. However, no such benefit exists for health professionals such as PAs and APRNs. PAs and APRNs are able to provide services, under their own names instead of a physician's name, and at a lower cost of care/reimbursement rate. An extension of direct supervision by audio/visual communication for PAs and APRNs would only serve to further impair data transparency through the potential proliferation of "incident to" billing.

Split (or Shared) Billing

A split (or shared) visit refers to an E/M service that is performed "split" or "shared" by both a physician and a PA or APRN in a facility setting and billable by the physician at the physician fee rate. Current Medicare policy authorizes split (or shared) billing to be used if the physician and PA/APRN are in the same group, the physician has a face-to-face encounter with the patient on the same calendar day as the PA/APRN, and the physician performs a "substantive portion" of the service. CMS currently defines a substantive portion as, "all or some portion of the history, exam or medical decision making key components of an E/M service". The split (or shared) billing mechanism has only applied to certain E/M visits and settings (i.e., hospital inpatient,

[6] http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0
[7] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf
[8] https://www.healthaffairs.org/do/10.1377/hblog20180103.135358/full/

hospital outpatient, hospital observation, emergency department, hospital discharge services) and has not applied to office settings (i.e., place of service 11), nursing facilities, or critical care services.

CMS proposes changes to split (or shared) billing to provide clarity, improve transparency, ensure program integrity, and better align policy with new CPT® guidelines for E/M services. Several proposed changes include:

- Redefining the definition of a "substantive portion" of the service to "more than half of the total time"
- Clarifying and expanding the settings of care and service types to which split (or shared) billing would apply, including adding new patient visits, critical care services, and certain Skilled Nursing Facility/Nursing Facility visits
- Distinguishing the Medicare split (or shared) billing policy from the CPT® E/M definition of a "shared or split visit".
- Defining "same group" and medical record documentation requirements
- Adding a claim modifier for claim identification

AAPA appreciates CMS providing greater policy clarity to avoid confusion and ensure compliance, implementing policies and mechanisms to provide greater transparency and attribution of services to the rendering providers, and expansion of services for which split (or shared) billing may be used.

Substantive Portion

AAPA agrees that the provider performing the substantive portion of the visit should be identified as the rendering provider of the service. However, we are concerned with the proposed change to the definition of a "substantive portion" and possible negative affects it could have on current practices and models of care. Requiring a physician to spend and document more than 50% of the time with a patient is a significant change from current practices and will be an administrative burden. Contrary to CMS' indication that some E/M visits that would be eligible for split (or shared) billing *are* (i.e., hospital discharge management) or *may* (i.e., office visits in hospital outpatient setting) be documented and billed based on time, the majority of services to which split (or shared) billing is applicable (i.e., initial and subsequent hospital inpatient, hospital observation, and emergency department visits) are not time-based services. Time-based documentation for services where coding and billing is not based on time would impose a substantial new burden, particularly in hospital and facility settings where visits may be interrupted by other necessary services or procedures and time may be burdensome to monitor. Furthermore, time alone may not be the best determinate of a substantive portion and making time the basis for split (or shared) billing could lessen the performance or value of the history, examination, and medical decision-making.

AAPA encourages CMS to retain the current definition of a "substantive portion" as "all or some portion of the history, exam or medical decision making key components of an E/M service", except for strictly time-based services (i.e., hospital discharge management services and critical care services), until a multi-stakeholder panel consisting of all relevant stakeholders, including PAs, can determine how best to define a "substantive portion".

Settings and Services

AAPA agrees with CMS that there is no reason to preclude billing for split (or shared) visits for critical care services and skilled nursing facility (SNF) and nursing facility (NF) visits. Allowing these services to be performed and billed in a split (or shared) manner is consistent with the collaborative, team-based approach to healthcare that has been demonstrated to increase quality and improve outcomes. This will also allow for greater flexibility for alternative payment models.

CMS is proposing to allow billing for split (or shared) visits for the subset of SNF/NF visits that are not required by their regulations to be performed in their entirety by a physician. AAPA encourages CMS to eliminate policy that mandates that any visit in a SNF/NF be furnished directly and solely by a physician and allow all required and optional services in a nursing facility to be performed individually by a PA or as a shared service with a physician. During the current Public Health Emergency, CMS authorized the delegation of “physician-only” visits in nursing facilities to PAs and other qualified healthcare professionals, if not precluded by state law or facility policy. This decision was based on the need to increase access to care while understanding that the flexibility would not adversely affect beneficiaries or the integrity of the Medicare program. During the nearly two years that this flexibility has been in place, there has been no reported adverse consequences related to the temporary policy change. To the contrary, nursing facilities have been able to use the flexibility to provide high-quality care. There is no clinical justification for re-instituting this outdated policy when experience has demonstrated the high-quality care PAs deliver in SNFs/NFs. PAs are clinically prepared, educated, and competent to deliver the full range of needed clinical care in nursing facilities. When PAs are authorized to deliver care to the full extent of their state law scope of practice, patient access to care is improved, especially in rural and underserved communities.

Clarifying CPT® Definition and Applicability to CMS Billing

AAPA strongly encourages CMS to clearly state that the CPT® definition of a “shared or split” visit does not apply to Medicare split (or shared) billing. As CMS indicated, the CPT® E/M guidelines state, “A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.” This might be interpreted to mean that when a PA performs the face-to-face components of the visit and a physician jointly performs some portion of the non-face-to-face work (i.e., reviews the medical record or provides care coordination), the physician could bill for the visit regardless of the service or setting. AAPA has grave concerns that this CPT® definition of a “shared or split” service, if applied broadly, could significantly obscure attribution and transparency, threaten quality-assessment, and greatly undermine program integrity.

Same Group

CMS, in accordance with previous split (or shared) billing policy, is proposing that a physician and a PA or APRN must be in the same group for the physician to bill for a split (or shared) visit and seeks comments on how to define “group” for these purposes. AAPA supports the definition of “group” as physicians, PAs, and APRNs working under the same tax ID and not requiring them to practice within the same specialty, which CMS proposes to define as the “specialty and subspecialty as the physician with whom they are working”, consistent with CPT® E/M guidelines. Because of the collaborative and interdisciplinary care that is needed in modern healthcare delivery, particularly when caring for critically ill patients, barriers to split (or shared)

services based on specialty would be detrimental and limit care coordination and delivery. For example, a PA specializing in cardiology should be able to split (or share) critical care services with a pulmonologist in the same group practice to provide the most appropriate, interdisciplinary care to manage life threatening illness or injury. **In addition, to allow for flexible employment and care delivery models, AAPA recommends that CMS clarify that for split (or shared) billing purposes, similar to "incident to" billing as indicated in Transmittal 1764, a leased PA would be considered in the same group as the physician or practice during the time for which the lease or contractual arrangement applies.**

Claim Identification

CMS proposes to implement a claim modifier that would be appended to claims for split (or shared) visits to identify services that were performed between a physician and a PA or APRN. AAPA agrees that accurate attribution of services is needed for quality assessment, resource utilization determinations, and future policy considerations. AAPA supports implementation of a claim modifier but further recommends that the collaborating PA also be indicated on the claim form. A modifier alone will not provide granular data as to the individuals providing the split (or shared) service, and the only way to identify the other practitioner would be through a burdensome medical record review**. Transparency and accuracy of both rendering providers is important for data analysis and interpretation. Therefore, the name and NPI of the PA participating in a split (or shared) visit, as well as a modifier, should be included on the claim.**

Critical Care Services

In addition to making critical care services eligible for split (or shared) billing, CMS proposes several other changes. CMS plans to clarify their definition of critical care visits and the requirements governing how critical care visits are reported when more than one practitioner or specialty is involved in furnishing critical care services to a patient. CMS also proposes to prohibit a practitioner that reports critical care services furnished to a patient from reporting any other E/M visit for the same patient on the same calendar day and prohibit practitioners from reporting critical care visits during the same time-period as a procedure with a global surgical period.

Definition of Critical Care

To improve transparency and clarity, CMS proposes to adopt the CPT® prefatory language as the definition of critical care services. The CPT® prefatory language states that critical care is the "direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition". CMS further proposes that critical care services could be reported by a physician or non-physician practitioner who is a QHP, defined under current Medicare policy as "an individual who is qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category to perform a professional service within their scope of practice and independently report that service".

AAPA is concerned that the Medicare definition of a QHP may be misinterpreted or misunderstood. Because PAs and APRNs in some States practice with physician collaboration or supervision, it may be interpreted that they may not "independently" bill or report a service for payment. Some states have outdated laws that

expressly prohibit a PA from "independently billing", but PAs in those states are still authorized to perform services and their employers may bill for them. **AAPA recommends that CMS amend the definition of a QHP to be "an individual who is qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category to perform a professional service within their scope of practice and report that service". AAPA also recommends that CMS expressly state in policy that for critical care billing, a PA is considered a QHP, when in compliance with State law, facility policy, and other requirements.**

Critical Care Services Furnished Concurrently by Different Specialties

CMS is proposing that critical care services may be furnished as concurrent care (or concurrently) to the same patient on the same day by more than one practitioner in more than one specialty. CMS is seeking comment as to when it would be appropriate for more than one physician or PA/APRN of the same or different specialties and within the same or a different group to provide critical care services. AAPA encourages CMS to not apply specialty or group restrictions on critical care services, other than requiring practitioners be in the same "group" for split (or shared) billing. Multiple practitioners in the same or different specialties and the same or different groups provide concurrent care, either simultaneously or over the course of a day, to patients who are critically ill.

AAPA recommends that CMS not limit more than one provider of the same specialty from providing and billing for critical care. Such a restriction would be problematic for PAs providing non-duplicative critical care services and practicing in different medical specialties, regardless of if they are practicing in a multi-specialty group or different groups. Because all PAs are identified by the same specialty code (i.e., CMS Specialty Code 97), a limitation requiring critical care to be rendered by providers of different specialties would limit a PA in cardiology and a PA in pulmonology from delivering necessary and distinct services.

Similar policies based on specialty distinction (i.e., new versus established patients and billing for same-day services by more than one provider per specialty) have limited utilization of PAs, reduced access to care for Medicare beneficiaries, and led to administrative burden through requests for redetermination of claims by Medicare Administrative Contractors. **CMS should avoid policies based on specialty that would limit PAs practicing in different specialties from providing critical care, same-day, and new patient services.**

Critical Care Visits and Same-Day E/M Services/Global Surgical Period

CMS proposes to prohibit a practitioner that reports critical care services furnished to a patient from also reporting any other E/M visit for that same patient on the same calendar day and prohibit practitioners from reporting critical care visits during the same time-period as a procedure with a global surgical period. However, non-duplicative and medically necessary critical care services may be needed on the day of other E/M visits and during a global surgical period.

Payment during a global surgical period currently includes post-operative services routinely performed by the surgeon or members of the same group with the same specialty, while critical care services unrelated to the surgery are separately payable**. Because these unrelated critical care services are often performed by providers other than the surgeon, they should remain eligible for separate payment.** For example, critical care services to manage a patient with a post-operative myocardial infarction resulting in cardiac

shock following a total hip arthroplasty should be separately payable from the surgeon's routine orthopedic post-operative care.

Similarly, distinct and medically necessary critical care and E/M services should be separately payable on the same day. A patient seen in the emergency department or during a subsequent hospital visit may require critical care services if their condition worsens and becomes life-threatening. For example, the same provider, particularly in critical access hospitals, may provide emergency department services and later need to provide life sustaining services such as advanced airway management, invasive hemodynamic monitoring, and other critical care services. **Clinicians should be paid for services provided that are reasonable and medically necessary at the time they were rendered, regardless of previous services that were provided and medically appropriate at the time.**

Medical Nutrition Therapy

CMS is proposing to revise the medical nutrition therapy (MNT) regulations (§ 410.130 and § 410.132) to amend the current requirement that a patient obtain a referral for MNT from their "treating physician." Under the proposed revisions, CMS would accept a referral from any physician, as opposed to the designated "treating physician." CMS states that this narrow definition has, in part, led to the low uptake of MNT referrals for Medicare beneficiaries. CMS also notes that the statutory language prevents the agency from accepting referrals from non-physician practitioners.

We agree with CMS that MNT is an evidence-based assessment that helps patients suffering from conditions such as diabetes and renal disease improve their diets and better control their disease(s). Despite being underutilized, MNT has been shown to be a clinically effective, cost-efficient way to help control and prevent diabetes complications, leading to better care for patients and lower costs for health systems. This type of preventive, non-invasive care should be equally available to all Medicare patients. Expanding access to these services will lead to lower costs and better care for beneficiaries. For that reason, AAPA supports regulatory and sub-regulatory actions taken by CMS that remove patient barriers to accessing MNT.

However, while we understand that CMS has interpreted the MNT benefit to require a physician referral, we continue to encourage the agency to use its authority to authorize PAs to refer for MNT. PAs are qualified to refer patients to dietitians or nutrition professionals for medical nutrition therapy and have demonstrated that they provide expert treatment and management of patients with diabetes and other medical conditions. For example, a recent study supported by the Center of Innovation to Accelerate Discovery and Practice Transformation at the Durham VA Health Care System, found that patients with diabetes managed by PAs and NPs received the same quality of care as patients managed by physicians, and had lower expenditure rates. The researchers found that "approximately $74 million could have been saved during the study year if utilization patterns of the entire cohort had more closely approximated those of patients treated by PAs and NPs."[9]

[9] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014

Examples of ways that CMS could authorize PAs to refer for MNT include:

- Utilizing the waiver authority under Social Security Act § 1115A to waive this barrier in CMS Innovation Center Models and utilizing the authority under § 1899 to waive this barrier in the Medicare Shared Savings Program. Using these waiver authorities would increase access to MNT for millions of Medicare beneficiaries.

- Clarifying that PAs are authorized to refer for MNT as a component of the Medicare initial preventive physical examination (IPPE) or the annual wellness visit (AWV). Under the SSA, Medicare covers IPPEs and AWVs when performed by PAs, the same as it would if those services were furnished by physicians. The definition of IPPE includes "referrals with respect to screening and other preventive services", and MNT is explicitly included in that definition. The AWV similarly includes referrals for preventive counseling services aimed at improving disease management. Thus, since the SSA states that Medicare covers IPPEs and AWVs when provided by PAs as it would when provided by physicians, and referrals for MNT are components of both the IPPE and AWV, Medicare should cover MNT when a patient is referred by a PA as a component of an IPPE or AWV. This interpretation is consistent with the SSA and would increase access to MNT for the millions of Medicare patients who are treated by PAs.

We encourage the agency to find a method to ensure that the patients treated by PAs and NPs have full access to medically necessary MNT services by authorizing PAs and NPs to refer for MNT.

Extension of Telehealth Category 3 Services

CMS proposes to retain services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023. In the 2021 Physician Fee Schedule, a new category of services was added to the Medicare telehealth services list. These services were added under PHE waivers and thought likely to be of clinical benefit when furnished via telehealth, but for which there was not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria. Services added on a temporary, Category 3 basis would ultimately need to meet the criteria under Category 1 or 2 to be permanently added to the Medicare telehealth services list. By retaining all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023, it will allow time to collect more information regarding use of these services and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the telehealth list.

AAPA appreciates the extension of the timeframe under which temporary services added on a Category 3 basis may remain eligible for Medicare payment. Increasing the range of services that may be performed via telehealth has been beneficial to Medicare beneficiaries, particularly those in underserved areas, with limited access to care, or who face other barriers to in-person care. The proposed extension of access to these services will allow for more time to better assess and support which services should be added on a permanent basis.

Teaching Physicians

CMS is proposing to clarify that the time when a teaching physician is present with a resident during key or critical portions of a service can be included when determining an E/M visit level. AAPA requests that CMS clarify, instead, that physicians, PAs, and other healthcare providers be able to include the time they were present with medical students, PA students, and other trainees when determining an E/M level of service.

Previously, CMS reduced administrative burdens regarding the training and preceptorship of students by authorizing in the 2021 Physician Fee Schedule that physicians, PAs, and certain other healthcare professionals may review and verify the documentation of students rather than redocument information in the medical record. This was done to eliminate the interpretation of previous guidance that created a disincentive to teach PA and APRN students. Interpretations of Transmittals 3971 and 4068, which suggested that PA and APRN preceptors could not verify PA/APRN student documentation, harmed the ability to train PA and APRN students. Health systems, hospitals, and practices adversely changed 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.

Similarly, policy such as this could be interpreted to limit the ability of physicians to be compensated for the time they participate in PA/APRN education or the time PAs/APRNs participate in the education of residents and other students would create similar problems. Physicians, PAs, and other healthcare providers should be able to count the time they were present with medical students, PA students, and other trainees when determining an E/M visit level.

AAPA urges CMS to use more explicit terminology in the final Physician Fee Schedule rule to eliminate any further confusion regarding documentation and selection of the E/M level involving the education of students. Specifically, we encourage CMS to clarify that PAs, like physicians, can count the time they were present with residents, PAs, and other trainees toward the selection of the E/M visit level. Also, it should be clarified that physicians, PAs, and APRNs can count the time spent with PA students and other trainees toward the E/M level determination.

Disparities and Equity

CMS' Request for Information (RFI) on the topic of reducing disparities and promoting health equity, contained within the 2022 Physician Fee Schedule, makes clear that these goals are a priority for the Biden Administration. This is further confirmed through the number of ways the topic connects to various aspects of the 2022 Physician Fee Schedule proposed rule (such as telehealth, quality programs, and data collection), as well as the inclusion of this RFI in various other proposed rules. As a first step, the proposed rule solicits ideas on how best to collect data on demographics and health inequities.

AAPA supports the goals of addressing disparities and promoting equity in healthcare. We agree with CMS' desire for increased specificity of data to address disparities and inequities as a logical first step. We encourage CMS to not confine its focus on ensuring robust data solely to demographic data, as other reforms in the ways in which data is collected may also support reductions in disparities. For example, the elimination of "incident to" billing would also lead to data specificity that would have a direct link to determinations of health equity. The increase in accurate attribution of services to the health professional

who provided the care would help provide a clear depiction of which health professionals are providing quality care, and which are not.

In addition to AAPA's support for CMS' appeal for more data, we believe there is more CMS can do to minimize health disparities and promote health equities, and that PAs can play an integral role in CMS' efforts. AAPA would like to draw CMS' attention to two sources of health disparities: 1) disparities caused by policies that restrict access to needed services, and 2) disparities caused by policies that promote the inefficient provision of care. It is our belief that policy changes, which AAPA has identified below, will better enable PAs to contribute to a more equitable delivery of care to patients.

Disparities in Care Resulting from Disparities in Access

Our healthcare system contains many barriers to access that affect beneficiaries unevenly, resulting in disparities. For example, both long wait times in high population areas with an insufficient number of providers, and a shortage of health professionals in a rural setting may delay access to care to the point that may be detrimental to patient health. Patients in these situations who are inhibited by financial constraints, health conditions, and transportation limitations have few options to gain access to care in a timely fashion and may be required to endure long wait times or forgo care altogether. This can create a discrepancy between the level of care received in these settings and in locations where care is easier to access.

PAs can help ease these access limitations. The US health system faces a clinician shortage, particularly in primary care, that is being exacerbated by an aging population.[10] As a result, PAs and APRNs are currently providing a substantial portion of the high-quality, cost-effective care that our communities require, and will continue to do so to meet the needs of their communities. As of 2017, there were more than 260,000 PAs and APRNs billing for Medicare services. According to the Medicare Payment Advisory Commission (MedPAC) approximately half of all Medicare patients receive billable services from a PA or APRN.[11] As noted by MedPAC, the number of Medicare beneficiaries being treated by PAs and APRNs continues to grow. However, if PAs and APRNs continue to face policy constraints that prohibit them from providing care they are qualified to provide, then CMS is unnecessarily constraining a powerful resource in its arsenal in addressing access disparities.

One example of an archaic policy that unnecessarily limits PAs and consequently the ability of patients to access essential services is the unnecessary requirements for physicians to provide certain services in skilled nursing facilities (SNFs). During the current public health emergency, CMS authorized the delegation of "physician-only" visits in SNFs to PAs, if there is no conflict with state law or facility policy. AAPA sees no clinical justification for re-instituting these outdated practice restrictions when years of experience has demonstrated the high-quality care PAs deliver in SNFs. Other examples of antiquated policies that limit access include the requirement that a physician be physically present for sufficient periods of time in a Critical Access Hospital to provide medical direction/consultation/supervision for services provided, and the requirement for a physician to perform a certain number of visits in Inpatient Rehabilitation Facilities. Each

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[10] Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4: https://aspe.CMS.gov/system/files/pdf/167396/NP_SOP.pdf
[11] MedPAC June 2019 Report to Congress, page 151: http://medpac.gov/docs/defaultsource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

of these requirements necessitate physician involvement that may not be readily available in rural settings, or available in a timely fashion in high-demand settings. PAs are clinically prepared, educated, and competent to deliver the full range of needed clinical care in these settings. CMS demonstrated an agreement with this position when it authorized PAs to provide such services in SNFs during the public health emergency. Patient access to care is improved, especially in rural and underserved communities, when PAs are authorized to deliver care in these settings to the full extent of their state law scope of practice.

In certain instances, patients are unable to access care most appropriate to their healthcare needs and desires. In such instances, patients should be able to transfer to another care setting with minimal difficulty. However, in emergency situations, if a patient requires a transfer and a physician is present, the physician must sign off on the transfer. If a physician is not present, a PA may sign off on the transfer, but only if they have first consulted a physician and subsequently receive a physician countersignature on the order. AAPA finds such requirements antiquated and inefficient. PAs can authorize a transfer in nonemergency situations and should be authorized to in emergency situations. Requiring a physician signature may result in frequent pulling of a physician from other patients. When a physician is not present, the requirement for physician consultation on any such transfers, especially in areas with a deficiency in the number of physicians available, may prolong the transfer process to a facility more equipped to meet a patient's immediate needs, thereby delaying access and potentially endangering the patient's health. The requirement for countersignature is then superfluous as the determination to transfer a patient has already occurred.

Disparities in Care Resulting from Policies that Perpetuate Inefficient Care Delivery

Certain Medicare policies, some regulatory and some legislative, impede the efficient delivery of care. Use of the "incident to" billing provision requires those health professionals who choose to use it to meet a series of requirements to be in proper compliance. Some of these requirements, such as the requirements for a physician to see the patient on the initial visit and for a physician to be within the suite of offices, create an increased burden that compromises optimal efficiency of care for patients seen under this arrangement. In addition, depending on one's geographic location, a Medicare Administrative Contractor may require additional documentation to meet "incident to" qualifications, creating an even more inefficient process for some based on the region of the country care is being provided. Due to the inefficiencies brought about by the numerous requirements for "incident to," in addition to transparency concerns already noted, this billing mechanism should be eliminated.

Similarly, other restrictive policies may prohibit PAs from helping some patients get a service in a timelier fashion. Examples of such restrictive policies include the prohibition of PAs from certifying terminal illness and admitting to hospice, the exclusion of PAs from being able to conduct the face-to-face evaluation prior to recertification under hospice, the inability to order therapeutic shoes without physician involvement, the lack of authorization for PAs to order Medical Nutrition Therapy, and the barring of PAs from interpreting screening mammography. When PAs are unable to provide these services, patients must wait for other health professionals, who may not be available, or available in a timely manner, to do so.

These CMS policies exacerbate disparities in care by creating situational discrepancies in access and inconsistencies in the efficiency or quality of care received. **AAPA requests that CMS review the policies identified here to determine what changes it can make to reduce inequities stemming from the agency's regulatory prohibitions.**

Flexibilities that Support Behavioral/Mental Health

In the 2022 Physician Fee Schedule proposed rule, CMS recognizes the toll the COVID-19 pandemic has played on behavioral/mental health and that the impact will extend beyond the confines of the public health emergency. As such, the rule identifies a number of proposals that seek to make it easier for Medicare beneficiaries to access needed behavioral/mental health services. This increased access is largely achieved by expanding the ways telehealth can be used to provide behavioral/mental health services. Specifically, CMS proposes to include a patient's home as an allowed originating site for mental health services after the end of the public health emergency, allowing certain audio-only mental health services be provided to beneficiaries located in their home (if the beneficiary is unable, or does not wish, to use two-way audio/visual technology), and authorizing RHCs and FQHCs to provide mental health visits via telemedicine.

AAPA is supportive of any flexibilities that would increase access to behavioral/mental health services. We recommend that any provisions be written in provider-neutral language as not to put constraints on patient access to available quality care during an attempt to expand access.
CMS also requests feedback whether the required in-person, non-telehealth service that must occur within six months of a behavioral/mental health telehealth service could be furnished by another health professional within the same group as the one who furnished the telehealth service. AAPA supports this concept and believes it holds potential to increase access through a more collaborative approach to care. AAPA recommends that CMS not unnecessarily restrict it to health professionals of the same specialty within a group. Specialty designation, depending on how CMS chooses to define it, may prohibit PAs and NPs, who under PECOS have their own specialties, from conducting the in-person visit for a physician, or vice versa. Any requirement of specialty would restrict groups from determining the most effective and efficient ways for their health professionals to provide care collaboratively and meet patient needs.

However, while AAPA applauds steps taken by CMS to increase access to behavioral/mental healthcare, we believe more can be done and that PAs can play an important role in increasing beneficiary access. With PAs demonstrating that they are qualified providers of behavioral/mental health services, further action by CMS on this issue can bolster the number of PAs practicing in relevant specialties to alleviate access concerns in a time when demand is increasing.

PAs Can Increase Access to Behavioral/Mental Health Services

PAs possess the tools required to treat mental and behavioral health conditions and alleviate the severity of access trends through their medical education in primary care, courses and rotations in behavioral and mental health, the authority to prescribe both controlled and non-controlled medications, and the experience of PAs practicing in psychiatry working in collaboration with psychiatrists.

Based on a broad generalist graduate medical education, PAs who specialize in mental health and substance use treatment expand access to limited but necessary care. PA education includes thousands of hours of didactic and clinical practice experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan from pediatrics to geriatrics, providing a foundation from which to address the diverse medical needs of people with mental illness or substance use issues.

PAs conduct histories and physical examinations; perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans and order referrals as needed. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals, where there are inadequate numbers of psychiatrists. In private practices, PAs conduct initial assessments, perform maintenance check-ups, and medication management for individuals on psychiatric medications. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, geriatric psychiatry, addiction medicine and care for individuals with posttraumatic stress.

PAs, working in collaboration with physicians and other members of the healthcare team, have been demonstrated to improve access to care with high levels of quality and patient satisfaction that is similar to that of physicians.[12] Authorizing PAs to deliver this high quality care to patients can help alleviate ongoing and worsening trends in access to behavioral/mental health services.

PAs Can Help Address Shortages in Behavioral/Mental Healthcare

Sixty percent of US counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health treatment and contributing to inadequate care and unsafe conditions.[13] A recent NYU study found that, while demand for mental health services is growing, patient access is shrinking.[14] The lead author postulates that shortages in professional help, as well as insufficient incorporation and training for mental health for primary care providers, may be contributing factors. Untreated mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.

Mental and behavioral health, much like healthcare generally, will soon feel the effects of worsening physician shortages, compounding already existing access issues. The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than necessary to meet the demand for services.[15] The National Council for Behavioral Health expects that, by 2025, there will be a deficit of 12 percent in the psychiatric workforce to sufficiently address patient needs.[16] An inadequate supply of providers of mental health services may lead to delays in diagnosis and care, rationing of available resources, ineffective care, and increased negative consequences of mental illness and substance use.[17] These

[12] Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from https://www.medpac.gov
[13] Substance Abuse and Mental Health Services Administration. 2019. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
[14] Heath, Sara. PatientEngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. Retrieved from https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows
[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. Rockville, Maryland. Retrieved from https://www.hrsa.gov
[16] National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. Retrieved from https://www.thenationalcouncil.org
[17] Ibid

problems will only be further magnified in rural areas. However, PAs are qualified to help confront these trends. PAs work to ensure the best possible care and outcomes for patients in every specialty and setting, interacting with patients with mental and behavioral conditions in primary care, emergency medicine, as well as in psychiatry.

The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics (2020), with a projected 31% increase in PAs from 2018 to 2028.[18] These qualifications and growth projections suggest that adequate utilization of PAs will continue to be an effective method of combatting mental and behavioral health workforce deficiencies and access concerns.

While only approximately 1,000 PAs practice directly with psychiatrists, this number has remained low due to excessive restrictions placed on PAs in this specialty. However, the recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act, CMS' inclusion of PAs as authorized providers in community mental health centers, and the establishment of PAs as mental/behavioral health providers at the state level.

Steps CMS Can Take to Amplify PA Contribution to Behavior/Mental Health

The contribution of the PA profession to behavioral/mental health is well established and will be relied on to a greater extent as trends continue. As such, AAPA requests that CMS update relevant educational materials, such as MLN1986542 on Medicare Mental Health to reflect recent policy changes and further reduce barriers of PAs contributing to the delivery of behavioral/mental health services. For example, on page 13 of the document, under the column "coverage," language needs to be updated in a similar manner as the comparable column under the Nurse Practitioners section (page 12) to reflect that PAs too "are authorized to supervise the performance of diagnostic tests in accordance with state law and scope of practice." Further, under the third column, "payment," CMS should update language by deleting bullet point two and modifying bullet point four to reflect the forthcoming change that will take place on January 1, 2022, which will allow PAs the receive direct payment for Medicare services. CMS should review other educational materials to identify and update similar dated language as needed.

In addition to clarifications that can be made directly by CMS, the agency could also communicate to the many payers with whom CMS contracts that prohibitive language by those organizations on the topic of PAs providing behavioral/mental health services should be eliminated. While many state Medicaid programs and private payers cover behavioral health services provided by PAs, some still do not. Communication by the agency, to payers with whom CMS works, regarding the importance of reducing unnecessary and obsolete restrictions on the provision of behavioral/mental health services could enhance access to care further.

Removing outdated language that may act as barriers to behavior/mental health care and signaling to other payers with whom CMS works to eliminate antiquated restrictions will allow for greater utilization of the PAs that currently practice in behavioral health and encourage a greater number of PAs to practice in related specialties. Increased demand for behavioral/mental health services

[18] U.S. Bureau of Labor and Statistics. 2020. Occupational outlook handbook: Physician assistants. Retrieved from https://bls.gov

requires the contribution of all qualified health professionals without archaic language or dated perceptions constraining access to care options.

Updates to the Quality Payment Program (QPP)

A Measured and Flexible Approach to Program Progression

In the 2022 Physician Fee Schedule proposed rule, CMS demonstrates that it wants to make minimal changes to the current workings of the traditional Merit-based Incentive Payment System (MIPS) program under the QPP. AAPA appreciates this both due to the unusual health environment we are in because of the pandemic, as well as CMS' intention to soon replace the traditional MIPS program with MIPS Value Pathways in the coming years.

Despite avoiding significant modifications to traditional MIPS and the QPP at large, CMS again proposes to increase the various performance thresholds that must be met in order to achieve a positive payment adjustment under MIPS. 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 practice improvement, as a large percentage of the participating health professionals were able to meet CMS' minimal performance thresholds. AAPA understands the need for CMS to raise submission standards and outcomes expectations as it continues the progression toward meaningful value-based reimbursement. The elevation by CMS of its requirements for success under MIPS, in conjunction with the removal of less meaningful quality measures, should lead to the attainment of a higher payment adjustment for those able to meet CMS' stated thresholds, and ideally provide more informative and actionable data in the process.

AAPA advises that some providers of care may still find it difficult to meet necessary thresholds resulting from unexpected stressors to the care delivery system over the past year. Consequently, AAPA also appreciates CMS' continued acknowledgement of context and its resulting flexibility, allowing providers to submit an application to reweight any of the categories to 0% due to extreme and uncontrollable circumstances, which can then be reviewed for need on a case-by-case basis. AAPA similarly approves of ongoing exceptions for small practices and bonus point availability for complex patients. We encourage CMS to continue to be mindful of unexpected burdens, especially those incurred by smaller practices, in the final years of traditional MIPS and through the transition to MIPS Value Pathways.

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, because 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 the PI score going to one of the other three MIPS categories.

When explaining its continued concern, the agency appears to question whether PAs and NPs have experience with Certified Electronic Health Record Technology (CEHRT) systems. While AAPA understands CMS' intention and appreciates its commitment to continued flexibility, AAPA is concerned about the pervasiveness of this perception and CMS providing this perspective through such a large platform. We wish

to affirm that not only are PAs capable of using CEHRT, but that they do so as a regular part of their jobs. PAs in most practice settings have been using electronic health record systems for years, and sometimes lead a practice's EHR system implementation. Consequently, PAs should be held to the same standards as physicians. We suggest PAs are fully ready and capable to participate under PI, with possible exceptions for small PA-owned practices that are unable to afford CEHRT systems that are fully compliant with current requirements.

If CMS further wishes to support PAs and NPs in their ability to report on CEHRT usage, the agency could officially require that CEHRT have full functionality for all health professionals that deliver medical care, including PAs and NPs. If health professionals, such as PAs, are prevented from fully accessing and utilizing CEHRT systems, the ability of the health professional to sufficiently provide care that is efficient, safe, and coordinated, as well as the ability to report on their use of CEHRT, may be jeopardized.

MIPS Value Pathways (MVPs)

To move away from a system in which health professionals and groups choose what to report from a large set of measures that are often not comparable, CMS has proposed to create a method of reporting in which a health professional or group selects a pathway, structured around a specialty or particular medical condition, that best aligns with the type of care typically provided. These pathways, or MVPs, would be built on a base of claims-based population health and care coordination measures and would be supplemented with measures that reflect activities one would perform for the chosen specialty/medical 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 clinical quality, outcome and cost performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and allow for quicker administrative and clinical feedback provided to health professionals to aid in the improvement of care. CMS further believes these changes will help remove barriers to Alternative Payment Model participation and accelerate the transition to value-based care.

In the 2022 Physician Fee Schedule proposed rule, CMS continues the process of implementing MVPs by proposing seven initial pathways for voluntary reporting in 2023. Additional MVPs will be introduced annually with the goal of MVPs replacing traditional MIPS entirely by 2027.

AAPA continues to support CMS efforts to reduce complexity in the MIPS program and enhance comparability. We caution that CMS' efforts at comparability remain encumbered by billing provisions such as "incident to" that obscure the accurate 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 inaccurate. While CMS is developing methods 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, which attributes services personally performed by PAs and NPs to a physician.**

CMS also provided greater detail about the MVP enrollment process indicating that enrollment would begin on April 1 and would extend to November 30. During that time, an MVP participant would select the MVP they intend to report to, as well as choose a population health measure they wish to report on, and an

outcomes-based administrative claims measure. After the deadline, an MVP participant will be unable to make changes or report to a different MVP.

AAPA approves of the large enrollment window, which should give participants the opportunity to determine which pathway is most appropriate for them to submit to. AAPA also appreciates that CMS has determined that self-selection is the most appropriate method of assignment to an MVP. We advocated for self-selection in our comments to the 2021 Physician Fee Schedule.

AAPA also strongly suggests that CMS not label which health professional specialties may submit to what MVP. This process is likely to result in CMS omitting certain specialties from participating in MVPs, which CMS itself expresses concern about. This suggestion of identifying which types of health professionals could report to which MVPs was identified as an alternative to the complicated question of how to define subgroups.

CMS proposes many options for subgroup definition, including limiting subgroup composition to a single specialty identified by the Provider, Enrollment, Chain and Ownership System (or PECOS), limiting composition to specialty families, or determining clinician specialties through claims data. In prior comments AAPA has expressed opposition to CMS determining specialty through PECOS. We noted how it would disadvantage PAs who are viewed by Medicare as practicing only in the specialty "physician assistant" and not the actual specialty in which they clinically practice. If PECOS is the determining factor of specialty in a single-specialty subgroup, PAs working in cardiology would be restricted from reporting with cardiologists in their office who provide similar care to comparable patients. CMS notes a similar concern regarding the effect of this method on PAs and NPs in its 2022 Physician Fee Schedule proposed rule. Specialty families and identification of specialties through claims data risks an inability for health professionals to properly align with a subgroup due to artificial groupings determined by CMS, and by CMS collected data that may be incomplete (as a result of billing mechanisms such as "incident to") or inconclusive.

AAPA believes that subgroup composition should not be defined by specialty, but instead by the shared relevance of an MVP topic for all subgroup participants. AAPA could conceive subgroups that are made up of health professionals from more than one specialty if they are reporting to an MVP that is focused on a condition that requires cross-specialty cooperation. For example, a subgroup in a wound clinic, that may submit to an MVP focused on non-healing wounds, could involve a health professional in internal medicine, a vascular surgeon or interventional cardiologist, a wound specialist, an endocrinologist, and an infectious disease specialist, all of whom are focused on providing regular care regarding non-healing wounds. Allowing varying compositions of subgroups and the data that results may even allow for CMS comparison of the most effective composition of health professionals in providing beneficial outcomes. Much like in the selection of an MVP, health professionals should self-select themselves into appropriate subgroups. We believe that health professionals are incentivized to choose both the most appropriate subgroup and the most appropriate MVP for them since, if they do not, their ability to score well on specialty-specific measures will be compromised and would negatively affect their reimbursement. AAPA suggests that subgroups could attest to the similar focus of its participants during MVP registration.

AAPA further supports requirements by CMS that Qualified Registries, QCDRs, and Health IT vendors be able to support MVPs relevant not only to their specialties but also their subspecialties. This is important as CMS has defined an MVP participant to include individuals, single specialty groups, multi-specialty groups,

subgroups, and APM entities, but that multi-specialty groups must form subgroups by 2025. AAPA also appreciates that CMS has indicated that subgroups inherit the eligibility of the entire group (using the group's TIN), as it is possible that a subgroup, which may only include one professional in a multi-specialty group, may not meet the low-volume threshold or other participation standards, on his or her own. This is especially true if that health professional is a PA or NP who is required by an employer to submit claims "incident to" another health professional in a practice.

It is essential that CMS take the necessary steps to get the implementation of MVPs right. When CMS is developing its full array of MVPs it must work with the provider community to identify potential gaps in MVP focus so that there are no health professionals who feel as if they cannot appropriately report to any of the available MVPs. It will be imperative that CMS ensure that there are a sufficient number and variety of MVPs to cover all participating health professionals**. We encourage the agency 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 because of their practice in multiple specialties.**

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. In addition, measures must be able to adequately capture various roles and responsibilities that may be filled by different health professionals on the 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 deliver care and will be expected to report must be consulted. The more accurately 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.

AAPA also believes that CMS recognizes the extent to which this will be another significant transition for providers. This is why CMS proposes to delay public reporting of data submitted through the MVPs. To further alleviate concerns regarding the transition to another reporting method, CMS must ensure that all relevant stakeholders are properly educated about the MVP choices, how to enroll, what is required for reporting, the potential monetary effects, and how to receive and act on feedback in a meaningful way. Efforts to educate those affected will also require adequate time for review, analysis, and a robust system to provide feedback. **AAPA suggests 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.**

Identification of PAs Under MIPS Quality Measures

In Appendix 1 of the 2022 Physician Fee Schedule, CMS identifies new quality measures that are proposed for the calendar year 2022 MIPS performance period. In the description of some of these measures, such as "Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System," and "Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions," the denominator identifies provider

types included for measurement. Among these provider types, PAs are listed as examples of primary care providers. AAPA cautions CMS to not assign PAs one label of provider type as PAs are generalists who work in both primary care and in specialty care. We are concerned that if PAs are categorized as one of these or another it would not be an accurate or fair depiction of the PA profession. **We request that CMS be vigilant in its descriptions as to not set a precedent of identifying PAs as only primary care providers or only specialists as to result in future interpretations that may limit a PA's ability to practice or report on care they are trained and qualified to provide.**

Thank you for the opportunity to provide feedback on the 2022 Physician Fee Schedule Proposed Rule. 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 michael@aapa.org.

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