



September 8, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1631-P  
200 Independence Ave., SW  
Washington, DC 20201

Dear Administrator Slavitt,

The American Academy of Physician Assistants (AAPA), on behalf of the more than 104,000 physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 proposed rule. PAs provide care under Medicare in all 50 states and the District of Columbia. As the first proposed Physician Fee Schedule (PFS) since the passage of the Medicare Access and CHIP Reauthorization ACT (MACRA) and the elimination of the Sustainable Growth Rate, the rule is tasked with laying the foundation for major policy and programmatic changes within Medicare. It is within that context that we draw your attention to our comments regarding CMS' planned modifications to PFS policy. For your convenience, we have divided our comments according to provisions of the proposed rule.

"Incident to" Policy Revision

The Fee Schedule rule proposes to amend §410.26(b)(5) to require that a physician or PA who bill for "incident to" services must also be the same physician or PA who is physically onsite providing direct oversight when that service is being performed. For purposes of transparency and accountability AAPA is supportive of the policy revision.

AAPA would go a step further and ask that CMS develop a methodology to track medical services delivered by PAs through the billing and claims process when services are billed "incident to" the physician. At present there is no opportunity for the claims processing system to determine the actual provider of care for PA-provided services that are billed "incident to" the physician. A much more cumbersome review of the medical record might be the only way to make that determination.

As the healthcare system continues to move toward advanced payment models and programs such as the Merit-based Incentive Payment System (MIPS) to determine how quality and efficiency metrics are achieved there is clear value in identifying the health professionals who actually deliver care to patients.

**AAPA agrees with the policy revision requiring that the billing professional also be the same professional who is onsite providing oversight for "incident to" claims. We also believe that it is imperative that CMS work closely with AAPA to increase the overall transparency of "incident to" claims by developing a method to clearly identify the PA who actually delivered the medical service that was billed "incident to" the physician.**

Assistance to Physicians to Employ a PA

As part of its efforts to expand access to medically necessary healthcare services and with an understanding of the primary care workforce shortage CMS proposes to create an exception to the Stark law and allow certain entities, namely hospitals, rural health clinics (RHCs) and federally-qualified health centers (FQHCs), to offset a proportion of the costs associated with physicians hiring PAs for a two year period if the PAs deliver primary care services. This change would mirror the existing Stark law exception

that allows institutional providers to offer recruitment incentives for physicians who relocate to the area served by the institutional provider.

We applaud the recognition of the increasingly valuable role that PAs play in primary care and CMS' understanding of the fact that the need for healthcare professionals will continue to grow as more Americans obtain healthcare coverage. With data showing that PAs are more likely to practice in rural communities as compared to physicians we understand that PAs are a natural fit to help broaden the rural healthcare infrastructure.

While the intent of the proposal is well-intentioned and may facilitate increased access to care in underserved communities we fear that the execution of such a plan may be flawed. A more meaningful approach would be to allow those same hospitals, RHCs and FQHCs to make incentives directly available to the PA as a way of encouraging PAs to practice in an underserved community. Those incentives could include loan repayment assistance, salary or bonus incentives and other ideas that would more directly influence a PA to move to and practice in a rural community.

**AAPA supports the availability of incentives to increase the number of PAs practicing in rural and underserved communities. While we appreciate the concept of hospitals, RHCs and FQHCs being able to provide monetary offsets to physicians who hire PAs, we believe that other methods of directly incentivizing PAs would be more effective in attracting PAs and expanding long-term access to care in these communities.**

#### Physician Value-Based Payment Modifier

The Value-based Payment Modifier (VM) is a quality incentive program that provides pay reductions for those who underperform based on Physician Quality Reporting System (PQRS) reported measures from two years prior. The Quality Tiering Methodology used under the VM adjusts providers upward, neutral, or downward based on performance. The VM program will expire in 2019 with the creation of the more comprehensive Merit-based Incentive Payment System (MIPS), which will consolidate aspects of many incentive programs under one composite score.

However, before completion of the VM program, CMS proposes to apply the VM to non-physician Eligible Professional (EP)-only groups and non-physician EP solo practitioners in the final year of operation, 2018. CMS is making such an extension only to certain non-physician EPs, of which PAs are included. AAPA is supportive of this action as the additional coverage of EP-only groups (that is, groups that do not include a physician) and solo practitioners continues the stepwise approach to coverage of the VM, filling in gaps of those providers that will be held similarly accountable under MIPS. We also appreciate CMS' intention, consistent with the addition of other provider groups in previous years, to hold the newly-added practitioners harmless from a downward adjustment based on Quality Tiering for the first year, despite it being the final year of the program. It is clear that CMS intends for this modification to expose more providers to this manner of reporting at little risk in order to prepare for the transition to MIPS.

**AAPA supports CMS' application of the VM to non-physician EP-only groups and non-physician EP solo practitioners in the final year of operation, as well as the intention to hold such newly eligible providers harmless from a downward adjustment.**

#### Physician Quality Reporting System (PQRS)

The PQRS, a program that incentivizes the reporting of quality measures, is another incentive program that will be absorbed under MIPS in 2019. Consequently, AAPA agrees with CMS' decision to maintain most of the policies and criteria it implemented for the 2017 payment adjustment, which is based on 2015 calendar year data, for the 2018 payment adjustment, which is based on 2016 calendar year data. We believe that consistency in quality reporting policies will be good for the transition to MIPS, which will capture quality measures as well.

AAPA favors CMS' proposal to continue to modify the measure set to add measures where there are gaps, eliminate topped-out or duplicative measures, and replace others. We believe that the continued

refinement as to which measures are used can carry over to MIPS. By vigilantly scrutinizing which measures are being captured, CMS is showing that it plans to remain fluid enough to evolve on what issues represent a more accurate depiction of quality care.

CMS did make one important modification to the way in which data is reported by adding the option for group practices to report quality measures using a Qualified Clinical Data Registry (QCDR). While this option has previously been available to individual EPs, the option for group practices is new. Recognizing that practitioners are already reporting data to registries, AAPA supports CMS' effort, which increases the number of reporting options and promotes more collected data that will be used for consumer comparison of providers. However, AAPA believes that additional reporting mechanisms maximize their benefit by being inclusive. Consequently, AAPA recommends CMS promote that those registries that report be inclusive of a wide array of providers, including PAs.

**AAPA agrees with CMS' decision to keep most policies for the 2018 PQRS payment adjustment consistent with the previous year, as this will support the transition to MIPS. AAPA also supports continued refinement of the measure set and the addition of the QCDR as a reporting mechanism, as long as such registries include PAs.**

#### Physician Compare

There continue to be significant changes and advancements under CMS' Physician Compare website. CMS continues to add to what data are reported, update how data are reported, and determine ways to translate the data for consumer interpretation for a more effective comparison of providers. AAPA agrees that, within reason of what's manageable and understandable to consumers, more information is better. As there was much that was modified regarding the Physician Compare site, we have separated our comments into sub-sections.

#### *The Public Profile*

In the proposed rule, CMS makes multiple changes to Physician Compare's Public Profile, the interface that consumers can view for information that will help them select a healthcare provider. These changes are proposed with the intention of ensuring that consumers have the necessary information and tools to make a proper comparison.

One change CMS proposes to make to the public profile is to begin linking to relevant information already found elsewhere. For example, CMS proposes to provide information on which Medicare Advantage plans a particular provider or group accepts, and linking to quality data on these plans that already exist on Medicare's Plan Finder website. In addition, CMS has requested feedback as to whether it should make 'open payments' data available on the public profile. Open payments data, or data on financial relationships between providers and other members of the health sector, are already available as well. Consequently, AAPA believes it would be beneficial to provide such information through Physician Compare by including a link from a provider's public profile to where it is currently housed. AAPA approves of this method. It adds important information that informs a consumer's choice of provider without unnecessarily cluttering a profile page. AAPA favors making public profile pages 'one-stop-shops' for information of interest to consumers, as long as the addition of such information does not unduly overwhelm the decision-making process. Any information provided, or linked to, on the public profile should be consumer-friendly and intuitive.

Another change CMS proposes is the addition of new icons and indicators to allow quick and easy understanding of whether a provider meets certain goals and expectations. One example is CMS' proposed addition of an indicator for reporting the new PQRS cardiovascular prevention measures in support of the Million Hearts initiative. AAPA approves of indicators in general, as long as they represent relevant information and their meaning is either intuitive or properly explained. We believe that such an indicator would help incentivize participation in a worthy program and would be consistent with current indicators for proper reporting through other incentive programs, such as PQRS and EHRs. Another example is CMS' proposal to add a 'green check mark' to an EP or group practice's profile page to indicate that they have received an upward adjustment based on the VM. CMS is soliciting advice as to whether it should include indicators signifying if an EP or group practice has received a neutral or

downward adjustment. In the interest of complete transparency, and to act as additional incentive for providers, AAPA would support the addition of these two supplemental indicators. However, we believe that the suggested addition of quality and cost composites on the public profile page may be too much information for a consumer without an understanding of how said composites were reached. Relevant information for comparison can be obtained from the adjustment. However, should a consumer be curious as to how such adjustment determinations were made, AAPA suggests that quality and cost composites be available through the downloadable database.

A third change CMS is proposing to make to public profiles is the Physician Compare Benchmark based on the Achievable Benchmark of Care (ABC) Methodology. Derived from PQRS performance, the benchmark, in the form of a five star rating, will provide a point of comparison between providers at the item or measure level, getting to the heart of Physician Compare's intention. AAPA approves of the five star rating format to translate the benchmark for consumer use as we believe the system is familiar and intuitive. We believe that it is important to make information easy to understand to the general public who are not used to evaluating data. We also approve of the fact that data used in determining the benchmark will be based on the most recent year available. This will provide professionals the opportunity to quickly rectify any negative score in a way that previous multi-year lags in data did not.

Finally, CMS proposes reporting measures stratified by race, ethnicity, and gender. AAPA believes that such information is important in determining and tracking health equity. However, while public reporting would better hold providers accountable, such data may be more useful included in the downloadable database, as opposed to on the public profile for consumer interpretation. It is possible that consumers would misinterpret such data and it would actually lead to an exacerbation of discrepancies. For example, if a patient deduces that a provider of interest does not perform many services, or perform well, on someone of their gender, race, or ethnicity, they may stay away from that provider based on minimal information.

#### *The Downloadable Database*

As opposed to the public profile, which is to be the outward-facing page to be viewed by consumers when comparing providers, the downloadable database holds additional information for the benefit of healthcare professionals and researchers. CMS proposes additional information to be included in the downloadable database.

Some additions CMS proposes for the downloadable database are information on the VM tiers (high, low, and neutral) for cost and quality, the most recent adjustment based on the VM, and whether an EP or group practice was eligible but did not participate by reporting. AAPA approves of the addition of this information. However, due to other proposed additions to the public profile in this proposed rule and the trend toward providing additional indicators on VM results, we can certainly see CMS eventually making such information available on the public profile. Should this information be later reported on the profile, AAPA would caution that many details must be accompanied by explanatory keys that boost patient awareness of what the data means, so providers aren't unnecessarily penalized in the minds of patients. An example of this may be the indication of program non-participation without explanation that absence of data does not necessarily mean negative data.

Another proposed addition to the downloadable database is the public reporting of utilization data, or counts of services and procedures by healthcare professionals. AAPA approves of this information being included and believes it ought to remain exclusively in the downloadable database. We believe such data will prove interesting for researchers, but would only be confusing for consumers.

#### *Data Submission*

CMS suggests in its proposed rule that it will make individual-level QCDR PQRS and non-PQRS measures available for public reporting and publicly report group-level QCDR data as well. As noted earlier in this letter, the reporting of data utilizing QCDRs at the group practice level is a new policy, as adding this option makes it easier for more providers to report quality data. AAPA approves of this change as it is consistent with its policy stated elsewhere in the proposed rule of making this an alternative option for reporting under PQRS. If this data is submitted, it should be reported in some fashion.



Regarding which providers may participate in Physician Compare, AAPA has noted that CMS seeks consistency in making the minimum threshold a sample size of twenty patients and statistically valid/reliable data. While AAPA recognizes that this threshold is low enough to encourage broad provider inclusion, we would like to encourage CMS to remember that determinations of full PA participation in the Medicare market are skewed by policies such as “incident to,” and “shared visit.” These policies contrast with CMS’ stated goal of appropriate attribution, but more importantly, obscure the fact that PAs actually see more patients than it may appear at first glance. There should be consideration of such nuances when setting minimum patient-load eligibilities. AAPA’s support for certain concepts outlined in this letter are dependent on CMS’ ability to assure appropriate transparency and the inclusion of providers like PAs in Physician Compare and the quality and value programs it reports on.

**AAPA approves of efforts to provide more information to consumers on the Physician Compare public profile, as long as the information provided is timely, understandable, reasonably manageable and accurate. AAPA supports the addition of new icons as long as they are intuitive or properly explained. However, AAPA believes that certain information, while helpful to be included in the downloadable database, is not beneficial to add to the public profile. Finally, AAPA requests CMS’ consideration of the effect of certain policies such as “incident to” and “shared visit” on consumer interpretation of PA data, as well as on thresholds that will determine PA inclusion in Physician Compare.**

#### MACRA’s MIPS Program

One issue discussed at length in the proposed rule is the effect of MACRA and the forthcoming MIPS program, which will replace PQRS, the VM, and Meaningful Use (MU) as of January 1, 2019. The intention of MIPS is to assess total performance through a composite score that will result in a payment adjustment. AAPA welcomes this upcoming transition to MIPS, as we see value in the simplification of the incentive process through consolidation. In the rule, CMS primarily focuses on three aspects of MIPS: The low-volume threshold, clinical practice improvement activities, and the effect on alternative payment models. We have commented accordingly.

#### *Low-volume Threshold*

CMS expressed an interest in feedback as to what metric should be used under MIPS for the program’s low-volume threshold to exclude providers. CMS had also provided three potential metrics to consider: The number of beneficiaries treated by an EP, the number of items/services furnished by the EP, or the number of claims. Comment was requested on which of these alone, or together, might be the best measure of a low-volume threshold.

AAPA finds value and concerns with each of these measures. However, we believe that the best metric would be the number of beneficiaries the EP treated, paired with the number of services provided, which would be defaulted to for examination should the first metric not be met. Our logic behind this choice is that the number of beneficiaries should be the primary metric, but that it would be possible to unintentionally leave out those who perform more work on sicker patients. Conversely, we find this option better than just measuring services provided because this removes the inclination to over-provide services on all patients if one can qualify by number of beneficiaries. Making the number of beneficiaries the primary threshold measure may serve to keep costs lower due to a focus on seeing more patients as opposed to providing more services. While not a perfect metric, this does possess the possibility of incentivizing care to be more effective and/or efficient.

When one or a combination of these measures is chosen, and the conversation shifts to the acceptable levels of this measure(s), AAPA requests that CMS consider that the work of health professionals such as PAs may not be attributed to the PA who actually delivered the care due to billing provisions such as “incident to.” We recommend that CMS examine new methods to increase the transparency within the billing process regarding who actually provides the service in such circumstances and assure that PAs are included in various incentive and reporting programs based on the level of patient care they actually deliver.

### *Clinical Practice Improvement Activities*

When established, the MIPS program will incentivize better performance under four components: Quality Measures (30%), Resource Use (30%), Meaningful Use of EHRs (25%), and Clinical Practice Improvement Activities (15%). While the first three can trace their origins to existing incentive programs (PQRS, the VM, and MU respectively), the fourth does not. CMS requests feedback regarding this final component.

CMS states in the proposed rule that the basic categories of Clinical Practice Improvement Activities include: Expanded practice access, population management, care coordination, beneficiary engagement, participation in an Alternative Payment Model (APM), and patient safety. However, suggestions are requested regarding the specific activities under these categories.

While AAPA will not list particular activities to include, we would recommend two potential guidelines for activity inclusion. First, given the nature of the component, AAPA believes that any activities should demonstrate efforts that go beyond what is expected, and potentially beyond what is currently incentivized, in order to demonstrate innovation and best practices. Second, CMS should take care to only include activities that are within the scope of practice of EPs like PAs. If EPs are unable to perform the activities needed to achieve a higher score, then the provider may be unfairly penalized for restrictions or narrow metrics that are beyond their control.

### *Alternative Payment Models (APMs)*

CMS uses the proposed rule to solicit general comments regarding the effect of MIPS on APMs while announcing a forthcoming Request for Information (RFI) and report on vulnerabilities. AAPA sees great value in the team-based, coordination-oriented approaches incentivized by many APMs. PAs have long been providers in such environments, and we recognize the benefits such models can provide to the system and patients in the form of high-quality cost-effective care. It is important to note that many APMs, by their nature, are implementing policies that MIPS plans to incentivize. While we look forward to the upcoming RFI and report, we request that CMS craft details of the application of MIPS to APMs with this fact in mind, allowing for flexibility for MIPS to capture what is already being done under APMs.

**AAPA sees value in the simplification of the incentive process through consolidation under MIPS. We recommend a low-volume threshold of ‘number of beneficiaries’ with a default to ‘number of services provided’ should the first metric not be met. AAPA requests that CMS give consideration to the fact that due to policies such as “incident to” and “shared visit,” PAs are not comprehensively tracked and any threshold should take this into consideration. AAPA further suggests a standardization of thresholds for future programs. Finally, AAPA recommends that activities under “Clinical Practice Improvement Activities” represent innovative and best practices and should be within the scope of practice of all EPs under MIPS.**

### Advance Care Planning Services

CMS proposes coverage of two CPT codes (99497 and 99498) which would reimburse a ‘physician or other qualified health professional,’ for advanced care planning, to include discussion of advanced directives. Recognizing the importance of these conversations, and the time it may take to explain, discuss, and help fill out forms, code 99497 covers the first 30 minutes, and code 99498 will cover subsequent 30 minute intervals.

AAPA agrees with CMS’ belief in the potential of early conversations regarding course of treatment and relevant options. We view CMS’ suggestion to pay separately for these codes as a vital incentive to make such conversations common practice.

Advanced care planning, and advanced directives in particular, are very delicate and personal issues. However, there is much support across the health sector for this process. AAPA believes advanced care planning has much potential to increase patient-centric, lower-cost care. Discussions of care options and considerations allow the provider to personalize care to reflect the patient’s preferences. In certain instances, patients making informed determinations of appropriate care may also result in a reduction in

cost from forgoing unnecessary or unwanted services. Finally, AAPA finds value in advanced care planning in its ability to nurture the trust and rapport between patient and provider.

Medicare statute currently covers advanced care planning under the Welcome to Medicare visit. However, AAPA views the visits as distinct in their purpose and encourages separate reimbursement to incentivize advanced care planning. The Welcome to Medicare visit sets a base understanding of a consumer's health and potential health needs. Advanced care planning addresses issues a patient may not be aware of upon enrollment, and may require condition-specific knowledge that would come up later. As to when such advanced care planning visits may occur, AAPA sees value in advanced care planning discussions being held at the patient's request or during an annual wellness visit with separate reimbursement.

Finally, AAPA is appreciative that the ability to conduct advanced care planning extends beyond physicians to 'qualified health professionals.' PAs are qualified professionals, capable of having discussions with their patients regarding medical options and appropriate, personalized courses of treatment. However, if PAs are able to discuss end of life care preferences, it would naturally follow that they ought to be able to order and provide such care. For this reason, AAPA believes the issue of advanced care directives further illustrates why PAs should be permitted to order, provide and manage hospice care.

**AAPA concurs with the importance of early discussions on treatment courses and options as they may result in potential improvements in the efficiency and patient-centricity of care. AAPA believes a separate incentive will aid in making this practice common. Finally, AAPA approves of qualified health professionals being able to provide such services, and purports that a PA's ability to perform this task should lead to a reexamination of current policy prohibiting PAs from providing hospice care as "attending physicians."**

#### The Medicare Electronic Health Record (EHR) Incentive Program Technology

In the proposed rule, CMS indicates its intention to revise the definition of EHR technology. The revised definition would make modifications to bring the technology in line with recent Office of the National Coordinator (ONC) criteria. EHRs would now require a certification that its technology can interact with CMS for the purpose of submitting clinical quality measures (CQMs).

AAPA is supportive of CMS increasing the number of ways to submit quality measures. Consistent with the fact that EHRs were envisioned to simplify processes, automate tasks, and reduce burden, this increase in interoperability between the various EHR systems and CMS should make quality reporting easier. Any improvement now to EHR communication with CMS will continue to benefit other incentive programs like MIPS that will require quality reporting and assess meaningful use.

However, while AAPA supports expansions to make it logistically easier to report, CMS can further promote comprehensive and accurate data submission by removing restrictions and applying appropriate incentives for those providers not currently included in the EHR incentive programs. Currently, PAs are not considered eligible professionals under the Medicare EHR incentive program, and are only eligible in limited circumstances under the Medicaid EHR incentive program, such as in PA-led Rural Health Clinics and Federally Qualified Health Centers. The appropriate inclusion of providers like PAs into the full use, reporting and access to incentive payments for EHR technology, the easier the transition will be to programs like MIPS, where all eligible providers will be responsible for such reporting.

**AAPA supports increasing the interoperability of EHRs with CMS' system for the purposes of submitting quality measures and recommends an examination of methods to further support data submission by incentivizing providers not currently incentivized for EHR use and reporting.**

### Chronic Care Management (CCM)/Transition Care Management

In the proposed rule, CMS addresses the possibility of covering ‘add-on’ codes, used in addition to current E/M codes, to fairly compensate providers for the professional component of care management and coordination services. Such services would be activities that are not currently separately reimbursed, such as education activities, coordinating care, managing medication, evaluating data, and modifying care plans.

AAPA sees value in such add-on codes as our health system transitions away from a focus on care episodes toward comprehensive treatment. We believe that if such codes are satisfactorily specified, provider reporting and reimbursement may become more accurate and representative of a provider’s time. We appreciate the recognition that there are important activities that require significant thought and time that must be performed, but are not currently documented or reimbursed for. Such tasks as planning and evaluation are important steps to get right, as many answers in medicine are not unambiguous. Such activities become even more important, and more intensive, with sicker patients that may have multiple chronic conditions. However, AAPA cautions that, should any cost be passed on to patients as a result of this change, patients must be made aware of these additional activities and their potential to impact the patient’s bill.

Finally, AAPA is appreciative of CMS’ intention to now cover CCM services furnished by FQHC and RHC clinicians. This rectifies a previous gap in coverage in locations where the need for these activities is the same as elsewhere. In the proposed rule CMS indicates, “CCM payment to RHCs and FQHCs would be based on the PFS amount, but would be paid as part of the RHC and FQHC benefit, using the CPT code to identify that the requirements for payment are met and a separate payment should be made.” AAPA approves of this method of reimbursement in FQHCs and RHCs and proposes that other services in RHCs be reimbursed similarly. For example, currently, PAs in RHCs may not bill for important and often required laboratory tests and x-rays, as these are Part B services. By modifying the method in which providers like PAs are reimbursed for such important tests, CMS can further promote appropriate reimbursement for necessary care.

**AAPA finds value in CMS covering add-on codes for the unmeasured care management practices that providers currently perform and are beneficial to treatment. However, AAPA supports the need to inform patients of such additional activities if patient costs will increase as a result. Finally, AAPA appreciates that CMS will now cover CCM services in FQHCs and RHCs and proposes that the method through which they plan to reimburse for such services be extended to laboratory tests and x-rays.**

### Telehealth

In the proposed rule, CMS adds six codes to the list of approved Medicare telehealth services relating to prolonged inpatient care (99356, 99357) and ESRD (90933-90936). At AAPA, we are in favor of robust coverage of telehealth services. Such a method of care delivery is particularly advantageous to patients who have severe illnesses that prevent travel and patients in rural locations for which travel would be costly. Many services of value to such patients can be performed at a distance. However, we note that CMS’ additions to the list of telehealth covered services in this proposed rule are limited when compared against the number of submissions provided for inclusion. Consequently, AAPA recommends that CMS give further consideration to which services can be safely and effectively provided via telehealth services to the benefit of patients.

**AAPA suggests that CMS consider a broader perspective of opportunity when selecting covered telehealth services.**

### Global Surgical Package

After the passage of MACRA, CMS was unable to implement its planned modification to the global surgical package, detailed in last year’s Physician Fee Schedule Rule, due to statutory prohibition. However, in the 2016 PFS proposed rule, CMS indicates it is still committed to a process to assign



accurate value to surgical services by capturing data on work levels associated with surgical global service periods.

AAPA certainly understands and appreciates the goals of determining appropriate levels of reimbursement, but we stress that modifications to the current system should not be carried out in a way that penalizes certain providers. We found CMS' previous proposal problematic in that the breakdown of the global surgical period as stated in last year's rule would have been at the expense of appropriate compensation of assistant surgeons, due to the fact that they would have been receiving the same percentage of a then smaller reimbursement. AAPA approves of a continued search for payment validity and recommends that considerations of fair compensation be kept in mind when ultimately determining new rates. Allowing proper time for feedback as to methodology, conclusions, and proposed modifications should also be sought from those stakeholders affected.

**AAPA supports CMS' intention to assign appropriate levels of reimbursement to services, but recommends that further examination of modifications to reimbursement for surgical procedures takes into account the effect of compensation on first assisting at surgery services.**

Thank you for the opportunity to provide feedback on the 2016 proposed PFS rule. AAPA welcomes further discussion with CMS regarding our positions. 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](mailto:michael@aapa.org).

Respectfully,

A handwritten signature in black ink that reads "Jeffrey A. Katz, PA-C, DFAAPA". The signature is written in a cursive style.

Jeffrey A. Katz, PA-C, DFAAPA  
President and Chair of the Board