



October 5, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

File Code 1734-P; Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 140,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the 2021 Physician Fee Schedule Proposed Rule.

PAs are authorized to provide medical and surgical care in all 50 states and the District of Columbia. PAs are committed to increasing access to high quality care for all Medicare beneficiaries and we seek to work in partnership with the Centers for Medicare and Medicaid Services (CMS) in both the development and advancement of healthcare policies that help in achieving that goal. To realize this objective, it is essential that Medicare's policies authorize PAs to practice at the top of their education and expertise. AAPA is grateful for the regulatory flexibility and waivers currently being implemented and proposed by CMS, especially in light of the COVID-19 Public Health Emergency (PHE). The agency has made significant progress in enhancing the efficiency and effectiveness of PAs by making changes to numerous policies dealing with PA practice. There remain additional opportunities to modernize Medicare policies related to PAs that will enhance both healthcare competition and beneficiary access to medically necessary care. It is within that context we draw your attention to our comments.

## **Increased Practice Flexibilities**

AAPA welcomes many of the policy changes CMS implemented under the agency's recent interim final rules, as well as those proposed in the 2021 Physician Fee Schedule. Through these rules and recent waivers the agency has demonstrated a willingness and ability to adapt policies to meet the changing needs of patients in our healthcare delivery system. These regulatory flexibilities benefit patients by reducing burdens that hinder access to care and fostering the availability of health professionals who can deliver timely care. Keeping this in mind, AAPA wishes to draw your attention first to the proposed flexibility authorizing PAs to supervise diagnostic tests, and subsequently to other policy changes to increase practice flexibility and improve care delivery to patients.

### *Supervision of Diagnostic Tests*

PAs are authorized to order and personally perform diagnostic tests consistent with their state law scope of practice. However, until recently, only a physician was authorized to supervise ancillary staff and trained technicians/professionals who are authorized to perform or assist in the performance of many of these tests. As a result of the Regulatory Revisions in Response to the COVID-19 PHE interim final rule (IFC 5531), PAs are now, on a temporary basis, authorized to supervise these same professionals who perform or assist in the performance of diagnostic tests. In the 2021 Physician Fee Schedule Proposed Rule, CMS is proposing to make this policy change permanent.

AAPA strongly supports the provision of the proposed rule that would authorize PAs to supervise technicians and other trained personnel who assist in the performance of diagnostic tests. PAs are highly qualified by training and education to perform diagnostic tests and are similarly capable of supervising other professionals in the performance of tests within their scope of training and clinical competence. Authorizing PAs to supervise diagnostic tests will improve efficiency in the healthcare system by eliminating the unnecessary requirement for a physician to be personally on site. Removing this outdated, administrative hurdle will expand patient access to needed diagnostic tests. AAPA urges CMS to finalize this proposal.

AAPA notes that CMS also plans to amend § 410.32 to add paragraph (b)(2)(ix) which would stipulate diagnostic tests performed by PAs in accordance with their scope of practice and State law do not require the specified level of supervision assigned to individual diagnostic tests, but rather that the relationship of PAs with physicians under § 410.74 would continue to apply. Until recently, this was already true. PAs were formerly protected under (b)(3) through a parenthetical that stated, "(However, diagnostic tests performed by a physician assistant (PA) that the PA is legally authorized to perform under State law require only a general level of physician supervision.)" In a recent interim final rule (IFC 5531), CMS removed this parenthetical and substituted it with (b)(2)(viii) which granted PAs this ability by exempting them from CMS' "basic rule" that requires an indicated level of supervision. However, the exemption specified in (b)(2)(viii) was indicated as temporary, lasting only through the PHE.

AAPA interprets this substitution to mean that CMS either inadvertently replaced explicit mention of a PA's ability to perform diagnostic tests under general supervision with only a temporary allowance of the

same, or, that CMS intended to maintain the parenthetical after the PHE, as evidenced by statements in the 2021 Physician Fee Schedule Proposed Rule that the proposed change would now *permanently* remove the parenthetical. It is essential that CMS clarify this issue to prevent future confusion.

**AAPA is pleased that CMS is proposing to make permanent the authorization for PAs to supervise diagnostic tests. Similarly, AAPA approves of CMS inserting explicit language under § 410.32 (b)(2) to make clear that CMS’ “basic rule” exempts PAs from the requirement of an indicated level of supervision.**

### *The Need for Additional Regulatory Relief*

In the 2021 Physician Fee Schedule Proposed Rule, CMS explicitly requests comment on whether certain flexibilities authorized under the recent interim final rules for the duration of the PHE should be made permanent. While CMS’ intention may be to only address issues mentioned in both the interim final rules and the 2021 Physician Fee Schedule Proposed Rule, AAPA urges CMS to take a broader approach and use the fee schedule final rule to make permanent a number of important flexibilities recently implemented on an interim basis.

AAPA believes the need for increased flexibilities, efficiencies and more effective utilization of all health professionals will not lessen when the PHE ends. Another flexibility, temporarily implemented through CMS’ COVID-19 emergency declaration blanket waivers, that should be made permanent is the removal of unnecessary requirements for physicians to provide certain services in skilled nursing facilities (SNFs). During the PHE, 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. PAs are clinically prepared, educated and competent to deliver the full range of needed clinical care in SNFs. Patient access to care is improved, especially in rural and underserved communities, when PAs are authorized to deliver care in SNFs to the full extent of their state law scope of practice.

AAPA also requests CMS consider addressing other regulatory barriers which hinder efficient practice. One such barrier is confusion over the authorization of PAs to sign a patient’s hospital admission order, without the need for a physician co-signature, when the order and admission history and physical are personally performed by a PA. Other examples of regulatory burdens placed on PAs involve the Medicare hospice program, including the restriction on PAs ordering medications for hospice patients if the PA is employed by a hospice organization, as well as the inability for a hospice-employed PA to be chosen to serve as an attending physician for a patient, if an attending physician had not been selected by the patient upon election of the hospice benefit.

**The Medicare program authorizes PAs to perform services that are otherwise provided by physicians. CMS should eliminate “physician-only” regulatory requirements for all Medicare services that are within a PAs legal scope of practice and for which PAs are educated and clinically competent to perform.**

### *Potential State Law and/or Facility Barriers*

As noted above, AAPA is grateful for CMS' willingness to implement flexibilities regarding care delivery in order to best meet the current and future challenges our health system faces. The identification of a number of these flexibilities has demonstrated that CMS listened to the input of health professionals regarding regulations and policies requiring increased flexibility to promote practice efficiency.

However, in the 2021 Physician Fee Schedule Proposed Rule, in a section dealing with scope of practice and related issues, CMS requests feedback as to state law and/or facility barriers that may run counter to its proposed flexibilities. AAPA is supportive of CMS collecting information on state and facility policies on such issues, but we strongly suggest that any such information not be a determining factor as to whether to finalize such flexibilities. Rather, this information will likely be more useful to CMS in determining initial utilization.

AAPA cautions that the collection of state and facility barriers to CMS proposed flexibilities for the purpose of determining whether such flexibilities be maintained would be counterproductive. A determination of whether a flexibility is warranted should be made based on whether the change would successfully increase care efficiency. To predicate the permanent adoption of a flexibility on the prevalence of current state or facility policies that may be out of date with current needs is not an appropriate metric by which to determine a flexibility's worthiness of implementation.

Often, states and facilities look to CMS for guidance as to what practice guidelines to permit and what not to allow, and structure their requirements and regulations to reflect CMS policy. If CMS indicates that a health professional is not allowed to provide certain services, states often echo similar language in their own laws and regulations in order to formalize consistent practice policies. Hospitals, for example, will frequently adopt Medicare policies to ensure eligibility for Medicare reimbursement.

**CMS should lead by example on the determination of need for policy flexibilities by determining the merits of such policy changes while meeting the growing needs of Medicare beneficiaries. States can then choose to change their laws and regulations to remove barriers and be in alignment with CMS policies.**

### **Direct Supervision**

In the proposed fee schedule rule CMS clarified an existing temporary policy for direct supervision implemented during the COVID-19 PHE. Direct supervision, as defined by CMS, requires the on-site presence and immediate availability of the billing clinician when the service is provided. During the PHE, CMS indicated through IFC 1744 direct supervision requirements may be met by the billing clinician being available via audiovisual communication. This flexibility was granted in recognition that the physical presence of the billing clinician may not be prudent or feasible in attempting to reduce the risk of COVID-19 exposure. CMS also recognized a temporary change in direct supervision was needed to 1) meet the increased demands on healthcare professionals, 2) facilitate the widespread use of telehealth, and 3) avoid the risk of patients not receiving timely medical care. However, in the IFC, it was unclear if the

billing provider had to maintain a real-time virtual presence and active audiovisual observation of the services they supervised. In the 2021 Physician Fee Schedule Proposed Rule, CMS clarified that billing clinicians need to be immediately available to participate via audiovisual technology, if needed, but do not need to provide real-time observation of the service or procedure. CMS proposes to maintain this flexibility in meeting direct supervision until the end of the calendar year in which the PHE ends or December 31, 2021, whichever occurs later. We urge the agency to make this provision permanent to facilitate increased patient access to care.

AAPA appreciates the flexibility in meeting direct supervision requirements and allowing services to be rendered in a manner consistent with minimizing exposure to COVID-19. AAPA also thanks CMS for clarifying that direct supervision may temporarily be met by the availability, as opposed to the active virtual or physical presence, of the billing professional. AAPA supports the flexibility in meeting direct supervision, and thereby “incident to” requirements. However, for the sake of transparency CMS should institute tracking methods to accurately attribute services to the professional who delivered the care when submitting services using Medicare’s “incident to” billing provision. When there is a lack of transparency regarding which clinicians are providing what services, it is difficult, if not impossible, to appropriately measure the type or volume of services or the quality of care delivered by each health professional. This can be particularly problematic when PA-provided services are billed under a physician. Accurate data collection and appropriate analysis of workforce utilization is lost. The impact of a lack of appropriate attribution of healthcare delivery may be even more detrimental during the PHE when an accurate analysis of such workforce data would be especially valuable in determining how to best respond to future health emergencies.

**AAPA encourages CMS to develop and implement reporting methods that identify the health professional performing medical services under the direct supervision of a billing clinician. We also urge the agency to make this provision permanent to facilitate increased patient access to care.**

### **Expanding Telehealth Services**

AAPA appreciates the Agency extending numerous regulatory flexibilities surrounding the provision of care to Medicare beneficiaries via telehealth during the PHE. Increasing the range of services that may be performed via telehealth and expanding the locations in which patients receive telehealth services has been beneficial to Medicare beneficiaries. Patients who lack physical mobility or transportation, have suppressed immune systems, or face other barriers to in-person care have greatly benefited from waivers allowing for flexibility, especially flexibility related to eligibility of originating sites. For many of these individuals, telehealth may be the only viable option to safeguard their timely access to needed medical care both during and after the PHE.

Growth in the use of telehealth has dramatically increased due to COVID-19. However, many of the recent telehealth regulatory expansions will cease when the PHE declaration ends. To maintain and promote the effective use of telehealth, many of the temporary regulatory relief policies must be made permanent through statutory changes or regulatory policy. In particular, AAPA encourages lifting

geographic restrictions to permanently include non-rural community access to telehealth services, and removing limitations on originating sites, making telehealth accessible to all Medicare patients from their homes. In addition, eliminating federal licensure restrictions across state lines and encouraging states to do the same will ensure the continued and efficient utilization of telehealth.

We support the process CMS proposes to establish for adding telehealth services to the list of services eligible for payment when rendered via audiovisual technology. According to the process, any proposed services are assigned to one of two categories and must meet certain requirements established for each category. Category 1 includes services that are similar to existing telehealth services and Category 2 includes services that are not similar to current telehealth services. In response to the PHE, CMS added a number of services to the telehealth services list and proposes to permanently add some of these services on a Category 1 bases. CMS also proposes to create a third, temporary category of criteria for telehealth services. Category 3 would be used for services added to the Medicare telehealth list during the PHE for the COVID-19 pandemic that will remain on the list through the calendar year in which the PHE ends.

AAPA recognizes the importance of providing flexibility while ensuring the delivery of quality care. We support the addition of the proposed services on a Category 1 basis and the continuation of other telehealth services, as suggested, through the calendar year in which the PHE ends. AAPA also encourages continued evaluation of telehealth services that can be permanently added on a Category 1 or 2 basis and, therefore, be eligible for payment under the PFS.

**AAPA encourages lifting geographic restrictions to permanently include non-rural community access to telehealth services, and removing limitations on originating sites, making telehealth accessible to all Medicare patients from their homes. In addition, eliminating federal licensure restrictions across state lines and encouraging states to do the same will ensure the continued and efficient utilization of telehealth.**

### **Evaluation and Management Services - Office Visits**

AAPA applauds the CMS decision to align the office visit evaluation and management (E/M) coding changes with the framework developed by the Current Procedural Terminology Editorial Panel and to implement significant increases in payment for office visits. This effort was the result of significant collaboration by numerous medical and specialty societies, including AAPA. CMS' new office visit policy will lead to significant reduction in administrative burden and better describe and recognize the resources involved in office visits as they are performed today. We must point out these office visit payment increases are required by statute to be offset by payment reductions to other services which leads to a reduction of nearly 11% to the Medicare conversion factor.

Due to the COVID-19 pandemic, many health professionals and medical practices face substantial economic hardships. We are concerned that the financial instability created by this public health crisis will be exacerbated by budget neutrality adjustments required when CMS implements the Medicare office visit payment policy in 2021. We strongly urge CMS/HHS to utilize its authority under the public health

emergency declaration to preserve patient access to care and mitigate financial distress due to the pandemic by implementing the office visit increases as planned while temporarily waiving budget neutrality requirements for the new Medicare office visit payment policy.

**We believe that there has been limited time and opportunity for health professionals to be properly educated regarding the new E/M coding and documentation guidelines. While medical associations, such as AAPA, are providing learning opportunities for its members, we urge the agency to increase educational and training opportunities and to approach any auditing and compliance activities with the understanding that many professionals have been fully immersed in caring for patients during the COVID-19 pandemic and have had limited time to focus on the new office coding and documentation changes.**

### **Electronic Prescribing of Controlled Substances (EPCS)**

CMS proposes to implement section 2003 of the SUPPORT Act, which requires that the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically in accordance with an electronic prescription drug program by January 1, 2022. CMS seeks information regarding criteria for granting exceptions to EPCS requirements and seeks to implement policies with minimal burden to prescribers.

AAPA supports EPCS to ensure that prescriptions are accurate, timely, and resistant to fraud and abuse. AAPA also thanks CMS for proposing to delay implementation and enforcement until 2022 to allow practices and health professionals, who are unusually strained by the current PHE caused by the COVID-19 pandemic, time to comply with EPCS.

However, in addition to time constraints and competing practice priorities, financial constraints may hinder practices and providers, especially those in small or rural practices, from acquiring electronic prescribing software needed for EPCS.

**AAPA recommends that health professionals and practices be able to declare a hardship and be exempt from EPCS requirements, if needed. In addition, health professionals who must comply with section 2003 of the SUPPORT Act, including PAs, need EPCS software that provides user access and the ability to prescribe without unnecessary burdens, while also ensuring flexibility in meeting any State law requirements related to prescribing of controlled substances. CMS should put forth guidance requiring medical practices, hospitals, and other health facilities to use software that is accessible by all prescribers and adaptable to State law and facility policy to ensure compliance with EPCS requirements.**

### **The Addition of Principal Care Management to RHCs and FQHCs**

In the proposed rule, CMS suggests implementation of Principal Care Management (PCM) codes G2064 and G2065 for certified rural health clinics (RHCs) and federally-qualified health centers (FQHCs). Recognizing that the existing Chronic Care Management service codes require patients to have two or

more chronic conditions to qualify for the benefit, PCM codes were created to expand the availability of chronic care management services to patients with only one high-risk disease or complex condition.

AAPA's comments to the 2020 Physician Fee Schedule Proposed Rule supported the creation of PCM codes, as well as the requirement for health professionals to receive patient permission prior to offering PCM services since patients may be responsible for additional costs (e.g., deductible and/or co-pays) for these services which do not require in-person contact between patients and health professionals.

AAPA is pleased to see the availability of PCM codes in RHCs and FQHCs. PCM services will be added to the calculation of the payment rate for general care management in RHCs and FQHCs. This payment methodology will lead to a more comprehensive tracking and assessment of care management services being delivered in these traditionally underserved communities.

**AAPA continues to advocate for additional CMS-developed patient education material regarding the benefits of care coordination services to help patients make an informed decision as to whether to elect to receive these services.**

### **Unintentionally Restrictive Terminology**

AAPA seeks to bring to CMS' attention the occasional use by the agency of language that can be interpreted as more restrictive than the agency likely intends. Specifically, use of the term "independent" has on multiple occasions caused confusion sufficient enough to merit direct corrective action by CMS. For example, CMS has twice revised official language to change the term of "licensed independent practitioner" to "licensed practitioner" in order to make clear that PAs are not excluded from ordering restraint and seclusion or documenting progress notes in psychiatric hospitals. AAPA requests that CMS maintain vigilance in avoiding similar terminology in the future.

PAs practice medicine and deliver patient care with a high degree of autonomy. They make independent medical decisions and are often a patient's primary care provider. However, using the term "independent practitioner" can be problematic.

AAPA would like to bring to your attention language used in the 2021 Physician Fee Schedule Proposed Rule when defining the term "physician or other qualified healthcare professional" in the context of Remote Physiologic Monitoring. The rule states that, "Accordingly, when referring to a particular service described by a CPT code for Medicare purposes, a physician or other qualified healthcare professional is an individual whose scope of practice and Medicare benefit category includes the service and who is authorized to independently bill Medicare for the service." CMS prefaces this definition by comparing it to the definition of the same term by CPT. However, the definition under CPT makes an important distinction in that it indicates the health professional independently *reports*, as opposed to independently *bills*. AAPA notes that the distinction is subtle, but important.



AAPA is concerned that some may read CMS' definition for the term and interpret it as only those who are authorized to receive direct reimbursement from Medicare, which PAs currently cannot, may be included under the term "other qualified healthcare professional."

While a broader reading of the context does not suggest an intention to exclude PAs, we are concerned that future interpretation of such a definition may be used to justify such an exclusion or lead to confusion. This issue will be compounded if this definition is formalized and used again by CMS in other contexts, as it currently is under the code descriptors surrounding Chronic Care Management services.

**AAPA requests that CMS modify this language to remove the word "independently" from the definition, or otherwise change the word "bill" to "report to" as used in the CPT definition.**

### **Changes to the Quality Payment Program (QPP)**

#### *A Measured Approach to Program Advancement*

CMS has chosen to generally maintain the existing framework for the 2021 Quality Payment Program (QPP) performance year that was laid out in the 2020 fee schedule. Updates are proposed to the Merit-based Incentive Payment System (MIPS) program to streamline some of the categories that were deemed as being overly complicated.

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.

CMS also proposes to continue to adjust the weights of the MIPS quality and cost categories to gradually increase the relevance of both scores. CMS has traditionally found it difficult to assign the cost of delivering care to the appropriate health professional. To quell concerns over this issue, CMS seeks to better refine cost measure attribution to alleviate inaccurate attribution. **AAPA appreciates CMS' attention to this concern to ensure that category measurements and scores are precise and meaningful.**

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

CMS informs that it again plans to provide flexibility for PAs and nurse practitioners (NPs) under the MIPS Promoting Interoperability (PI) category. Specifically, as a result of CMS' uncertainty as to whether PAs and NPs have the appropriate knowledge and familiarity with electronic health records (EHRs) to

participate, reporting for these health professionals will be optional, with an automatic reassignment of the PI score going to one of the other three MIPS categories. AAPA understands CMS' intention and appreciates the continued flexibility as it sought to further assess PA and NP EHR capabilities.

However, 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 Certified Electronic Health Record Technology (CEHRT) systems that are fully compliant with current requirements.** PAs in most practice settings have been using electronic health record systems for a number of years, often being the health profession who leads a practice's EHR system implementation and should be held to the same standards as physicians.

#### *MIPS Value Pathways (MVPs)*

CMS has delayed the implementation of the MVP program until the 2022 MIPS performance period due to the current pandemic. AAPA appreciates that administrative flexibility during a time that has been uniquely challenging for virtually all health professionals.

In an effort to move away from a system in which health professionals and groups choose what to report from a large set of measures that are often not comparable, CMS proposes to create a method of reporting in which a health professional or group selects a pathway, structured around a specialty or particular medical condition, that best aligns with the type of care typically provided. These pathways 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.

AAPA continues to support CMS efforts to reduce complexity of 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 hence 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.

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

A question to which CMS explicitly requested feedback is related to how the agency could determine MVP assignment. CMS indicated it is considering various methods to assign an individual or group to a specific MVP, including looking at the specialty reported by a health professional on a Part B claim, or by drawing necessary information from the CMS Provider, Enrollment, Chain and Ownership System enrollment data. However, these methods are concerning to 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 PAs are not assigned to a specialty-specific pathway that reflects their practice, as opposed to their provider type, we are concerned they may be excluded from participation in MVPs and be required to report under the current process, which, by CMS’ own admission, is more complex and less beneficial. Any method CMS might use to assign a specialty is prone to error and has the potential for increased administrative burden if practitioners appeal CMS’ specialty assignment. AAPA, instead, recommends specialty self-selection with attestation for PAs. Health professionals are incentivized to choose properly since, if they do not, their ability to score well on specialty-specific measures will be compromised and would negatively affect their score and reimbursement.

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

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 as a result of their practice in multiple specialties and the manner by which they are identified as a provider specialty by the Medicare program. Health professionals like PAs and NPs also have interest in ensuring that newly developed measures are structured or phrased in a way that is inclusive. 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. CMS states in the proposed rule that it plans to work with clinician professional organizations on implementation details and we offer our assistance in any way the agency would find helpful.

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

AAPA recognizes there may be some variation in the level of measurement requested, as well as the number of measures used, between the specialties/medical conditions in the various MVPs. We understand this variation may be necessary to accurately and adequately capture successful practice patterns. However, AAPA warns against significant variation in requirements or administrative burden from one MVP to another so as not to create a disparity across specialty types. CMS must be mindful of the potential burdens placed on small and rural practices as measures are developed. We recommend CMS hold discussions with health professionals in these particular practice settings to determine which solutions may best alleviate administrative burden, limit disruption to patient care, while maintaining CMS' ability to capture useful data.

AAPA cautions that the scope of this reporting system change and the short timeframe to potential implementation necessitates sufficient education to relevant health professionals and other stakeholders. 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. Another method to reduce potential confusion MVPs is to maintain and carry over as many measures from the current system as possible, as long as those components don't create additional burdens or confusion.

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

We realize the complexity involved in implementing this enhanced MVP program and AAPA stands ready to engage with the agency to ensure success.

**AAPA supports CMS’ measured approach to advancing the QPP program. CMS should begin to expect PAs and NPs to participate fully under the MIPS Performing Interoperability category with possible exceptions for small PA- and NP-owned practices that are unable to afford EHR systems that are compliant with current requirements. In order to improve the value of QPP data, CMS should take necessary steps to rectify the problem of data accuracy by addressing the complications brought about by the “incident to” billing method which attributes the medical services delivered by PA under the name of a physician. For optimal comparability, CMS should 1) limit the number of MVP pathways by not breaking up specialties into an excessive number of MVPs; 2) attempt to align requirements based on data submission method, and 3) limit variation of reporting requirements between health professionals using the same MVPs. CMS should provide more opportunities to comment on the details of MVP implementation, reaching out specifically to various affected health professional stakeholder groups in various practice settings. CMS should choose measures for the MVPs both by reviewing current effective measures, as well as by soliciting measure ideas from the public and other stakeholders. CMS should ensure a robust education campaign on MVPs prior to implementation. Regarding multi-specialty groups and MVPs, CMS should allow for sub-specialties to report under different MVPs to allow for distinct assessment and feedback by subspecialty and should release ideas it may have for aggregation for reimbursement purposes sufficiently in advance for public comment. Finally, CMS should allow PAs to self-select into an MVP based upon the specialty in which they practice.**

Thank you for the opportunity to provide feedback on the 2021 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](mailto:michael@aapa.org).

Sincerely,

A handwritten signature in black ink that reads "Beth Smolko". The signature is written in a cursive, flowing style.

Beth R. Smolko, DMSc, MMS, PA-C  
President and Chair of the Board