



August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 115,000 physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP) proposed rule. AAPA is pleased to provide the PA perspective to the ongoing design and implementation of the QPP. AAPA offers the following constructive comments, which are organized by topic below.

Data Accuracy and Accountability

AAPA reiterates our concern about the accuracy of the data that will be used as part of the QPP, since so much of the agency's QPP efforts are dependent on the collection and analysis of accurate and actionable data dealing with quality, outcomes, resource allocation, and other factors.

Unfortunately, the care provided by PAs is often attributed to physicians. This means that any payment system that seeks to assess value and outcomes, and reimburse accordingly, is likely to be fundamentally flawed. It affects the determination of which professionals qualify for inclusion, the composite scores that are assigned to health professionals, and whether a professional is listed on the Physician Compare website. Quite simply, PAs may not be able to fully participate in the QPP program because the services they deliver to Medicare beneficiaries are often not properly attributed to them.

In the transition to both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs) it will be essential to ensure that CMS policies support the accurate reporting of information and metrics for the QPP. The Medicare program has a billing and reimbursement policy that has the effect of concealing the identity of certain healthcare professionals, including PAs, who deliver direct care to the patient. The Medicare program allows services provided by PAs in a private office or clinic to be billed under the name and NPI of the collaborating physician using a

billing mechanism known as “incident to.” When services delivered by PAs are billed under the name of the PA’s collaborating physician as an “incident to” service, the PA’s name and NPI typically do not appear on the claim form. This means that the actual provider of care, in this case the PA, is not identified in the CMS claims system and QPP data sources are populated with information that does not identify the actual provider of care. PAs report that as much as 40-60 percent of the services they deliver in the private office setting are billed “incident to” the physician.

While PAs are considered eligible clinicians (ECs) in the QPP, this does not guarantee program participation. To maintain eligibility, PAs, physicians and other health professionals must exceed a “low-volume threshold,” which means having more than \$90,000 in Medicare billing charges or providing care for more than 200 unique Medicare Part B enrolled beneficiaries in a calendar year. Although PAs may actually treat a sufficient volume of eligible patients, they may not be recorded in the CMS claims system as having treated the requisite number of patients or billed for the appropriate amount because a substantial number of their patient visits are billed under a physician’s name using “incident to” billing - thereby falling below the eligibility threshold. As long as a portion of the services delivered by PAs are “hidden”, the threshold will be a problem and the work performed by the PA will be inappropriately assigned to a physician who did not personally perform the service. If CMS intends to create similar incentive programs or measure sets under Medicaid, this situation will be compounded because eight states do not accept the PA’s name and NPI on claim forms, contributing even further to the hidden provider problem.

The inability to accurately capture the identity of the health professional that is actually providing a specific service causes problems that go beyond program eligibility determinations. Health professionals will have participation and performance information posted on CMS’ Physician Compare website, a publicly-facing resource through which patients may seek to compare and choose health professionals. For those PAs who are included on Physician Compare, the information about them will be inaccurate, due to “incident to” billing of PA-provided care that is attributed to a physician; it could mask the services performed by some PAs altogether. This means patients may make decisions regarding selection of care professionals based on incomplete or inaccurate information, and potential employers may use the inaccurate scores on Physician Compare to make hiring decisions about either PAs or physicians. Further, if practitioners are omitted from Physician Compare as a result of not meeting eligibility requirements for MIPS, the site may give the false impression to patients that an otherwise available health professional in their community is not an option from whom they can receive care, thus decreasing access.

The premise of QPP and other health-related programs is that evidence-based, quality-driven information should guide clinical practice and be used to evaluate performance, and it is essential that the data underlying these programs accurately reflect the care being provided by each health professional. CMS must ensure appropriate provider attribution and eliminate the problem of “hidden” providers. The first step is to require the name and NPI number of the rendering provider (i.e., PA) on all “incident to” claims.

For purposes of accountability and in keeping with the goals of the QPP, AAPA recommends requiring claims submitted using the “incident to” billing provision to specifically include the name and NPI number of the PA who actually provided the care. This information should be clear and traceable on the standard CMS paper form and through the electronic claim submission process. For example, the shaded portion of box 24 J (rendering provider ID #) on the CMS-1500 claim form may be the

appropriate place to add the PA's NPI as the provider of care. This process would not change the fact that the claim is billed under the collaborating physician or the payment amount, nor would it change the fact that payment is made to the PA's employer. It would simply improve the accuracy of the data and allow an honest assessment of which health professionals meet the patient volume and dollar threshold criteria of the QPP.

In addition, CMS should encourage Medicaid programs and commercial insurers to enroll PAs and include their name and NPI on claims for services they render, because this data may impact whether health professionals in an Advanced APM entity meet the APM Qualified Professional (QP) threshold through the "all payer/other payer" combination option.

Increasing Flexibility under the QPP

In the proposed rule, CMS makes apparent that a primary goal of the rule is to introduce additional flexibilities into the QPP where possible. AAPA supports CMS' efforts to ease the administrative burden of participation under the QPP. We would like to note some of these flexibilities specifically, and offer further comment.

First, CMS has indicated it will show increased flexibility for those who submit the same measure through two different mechanisms. CMS indicates the agency will only count the submission that results in the highest score. Similarly, CMS states if an individual or group chooses to report more than the minimally required six quality measures, the agency will choose the score combination most favorable to the individual or group. While AAPA appreciates CMS' willingness to assess health professionals on those measures that will result in the highest score, we also caution that allowing individuals or groups to report more than the required number of measures may disproportionately advantage those practices and health organizations that have a more robust infrastructure and capacity. Consequently, a large hospital system with the resources and administrative infrastructure to submit numerous measures would increase their likelihood of achieving success, that is a higher score, over smaller practices, for example, that are unable to submit as many measures. AAPA recommends CMS explore options to mitigate this disparity without removing the ability to submit more than the minimum number of measures.

Second, CMS has provided more details for the "All Payer" option for data submission, in which an Advanced APM can submit data from all APMs, not just Medicare APMs, starting in 2019 in order to increase the likelihood of achieving QP status. This option will be implemented in a stepwise manner. In other words, if an Advanced APM does not meet QP status under "Medicare Only" APM data, only then will CMS assess QP status based on the broader All Payer option, which requires significantly more detailed reporting. AAPA looks forward to the All Payer option as an additional opportunity to achieve QP status. Health professionals in Advanced APMs may fall short of QP status when looking solely at Fee-for-Service Medicare patients, but may meet QP thresholds when examining a larger patient population. AAPA believes that such an expanded perspective will reaffirm CMS' support for the stated purpose of Advanced APMs by encouraging the delivery of value-based care to a larger sample of patients.

Third, CMS has indicated that clinicians in hospitals will be permitted to participate under MIPS in a voluntary manner by using Hospital Value Based Purchasing program data/measures. AAPA encourages

CMS to continue to identify efficiencies in MIPS by utilizing proven reporting efforts already in use to count toward QPP reporting (see also our comments on CMS' inclusion of PICME as an Improvement Activity on page six of our comments). To the extent possible, it is important that program guidelines be applicable across different practice settings to avoid having multiple reporting systems in conflict with one another.

Fourth, CMS has expressed an interest in accommodating groups or types of practitioners who are limited in their ability to successfully report on certain measures categories under MIPS. First, AAPA appreciates that CMS will allow ECs to request category reweighting assessments for uncontrollable/extreme circumstances, such as natural disasters. In addition, CMS has proposed to continue its flexibility regarding who must report on the Advancing Care Information category. CMS intends to allow for small practices to apply for hardship exceptions from this category. Furthermore, CMS has stated that it does not yet have sufficient data on the level of EHR utilization under the QPP by classes of health professionals who did not have widespread experience with CEHRT under prior Medicare and Medicaid incentive programs. Thus, Advancing Care Information will remain optional for PAs, NPs, CNSs, and CRNAs. AAPA recommends that, as sufficient data may not become available in the near future due to QPP transitional policies like Pick Your Pace, CMS work with those associations that represent the professions indicated as exempt in crafting a plan for future years and in identifying which Advancing Care Information measures may be most accommodating to health professionals reporting on this issue for the first time. AAPA stands ready to assist CMS on this matter.

Fifth, CMS has proposed to explore allowing health professionals who are part of multi-specialty groups to report on measures and activities as separate subgroups. AAPA agrees that finalizing this proposal would allow professionals to report on those measures that are most appropriate to their patient mix, and believes the proposed change would bolster practice improvement and incentivize quality care. A multi-specialty group with internal medicine and gastroenterology professionals may well find it difficult to agree on a common set of measures, which may result in the selection of compromise "generic" measures that do not reflect the most appropriate measures for anyone in the group. Subgroup submission is an important step in increasing reporting flexibility. AAPA further recommends CMS allow PAs to report in the subgroup which reflects their specialty. Medicare does not categorize PAs by specialty. It would be important for PAs to be authorized to report in the specialty subgroup in which they practice.

Sixth, CMS has proposed that submission of MIPS data can now be done through multiple reporting mechanisms for measures in the same category, as opposed to requiring that a method of data submission be consistent within a category. AAPA understands CMS' intention to not limit an EC's ability to report on any quality measures applicable to them. We agree that health professionals should not be constrained in MIPS participation based on the particular EHR or registry used. However, we have concerns that utilizing a patchwork of different submission mechanisms could increase confusion in both the reporting of measures by health professionals and collection and analysis of that data by CMS. While a more centralized reporting mechanism may improve data submission and collection activities, CMS must be mindful of the infrastructure costs and administrative burdens that may occur at the practice level by allowing appropriate time for such transitions to occur.

Seventh, AAPA agrees with CMS' proposal to continue to be flexible in permitting MIPS eligible clinicians to use Certified Electronic Health Record Technology (CEHRT) certified to the 2014 Edition while merely incentivizing the use of CEHRT certified to the 2015 Edition. We support the use of CEHRT to improve

healthcare and encourage the use of the latest versions of software to take advantage of improved functionalities. However, PAs, many of whom practice in small and rural practices or underserved communities, may be at a disadvantage in adopting the 2015 Edition. Allowing MIPS eligible clinicians to continue to use EHR technology certified to the 2014 Edition for the performance period in CY 2018 will help PAs meet the Advancing Care Information requirements under the QPP.

Finally, CMS has proposed to maintain the category weight distribution used in 2017, keeping the weight of the Cost category at zero, and the Quality category at 60%. AAPA supports this continued flexibility. However, as there exists a statutory requirement that in 2019 the weight of both the Quality and Cost categories be 30%, AAPA requests that any feedback reports released prior to 2019 also include a simulated composite score estimating the effect and payment adjustment if the weight of both Quality and Cost were set at 30%. This simulation will help give health professionals a better idea of the net impact of the percentage distribution that is scheduled to occur in the 2019 performance year.

Health Professional Reporting and Performance Requirements

In addition to those provisions contained in the proposed rule aimed at enhancing flexibility, CMS also included provisions which increase the requirements for health professional reporting and performance. Many of these changes are a result of CMS previously setting requirements low, in order to ease the transition to this new program. For example, CMS has proposed increasing the Data Completeness Threshold, the amount of data relevant to a given metric that must be submitted, from 50% to 60% in 2019. This should advance the level of relevant information submitted by health professionals in a stepwise manner, eventually leading to a volume of required submission that will prevent cherry-picked data. In addition, health professionals that fall below this percentage threshold will now only receive one point for that measure, with the exception of small practices that will continue to receive three, as was policy in the 2017 performance year. AAPA supports the gradual increase of the Data Completeness Threshold, and appreciates that CMS has provided two years advanced warning of an intended increase.

Similarly, CMS has begun to raise the performance threshold. In 2017, minimal reporting through “Pick-Your-Pace” was sufficient enough to achieve the stated three point performance threshold to not receive a negative adjustment. As a result, the transition year intentionally made it simple to not receive a negative adjustment. However, as not many health professionals will fall below the three point threshold, and MIPS is a budget-neutral program, CMS has similarly curtailed the size of any positive adjustment. For performance year 2018, CMS has proposed to increase the performance threshold to 15 points. AAPA approves of the size of this increase, as we believe it demonstrates an intention to advance the program to one that promises sufficient reward for participation, while also signaling movement toward this will be done at a measured pace. Whether 70 points remains appropriate for the exceptional performance threshold, which indicates which health professionals will receive and split the exceptional performance bonus, remains to be seen, as we do not yet have any data by which we can comment whether the intended bonus money is overly diluted by a high number of qualifying clinicians.

CMS has also proposed modifying the definition of a “rural” practice, making it a harder status to achieve. Formerly, one could qualify as “rural” if just one office, for example, was physically located in a rural setting. This low threshold has likely granted rural status for some health systems that may not have truly merited it. For example, a large urban hospital system, with one satellite location in a rural setting, would currently be able to achieve rural status. CMS now proposes to raise the requirement to

having 75% of NPIs practicing in a rural/HPSA identified zip code. AAPA approves of this modification, especially in light of the fact that CMS is considering adding additional flexibilities for rural settings. This modification may ensure that such program and administrative relief advantage those to whom it was intended to benefit.

QPP Measures

Continuing Medical Education as an Improvement Activity

AAPA supports the proposed new Improvement Activity titled, “Completion of an Accredited Safety or Quality Improvement Program,” for QPP year 2 and future years. We believe the inclusion of this Improvement Activity is in line with AAPA’s recommendation in response to CMS’ QPP year 1 final rule, which requested that continuing education of the caliber of AAPA’s Category 1 PI-CME be included as Improvement Activities under MIPS. We can attest that all activities eligible for AAPA’s Category 1 PI-CME meet the criteria proposed as 2018 updates to the QPP. The approval of existing practice improvement metrics and programs as Improvement Activities that meet appropriate and objective standards will capitalize on established systems that already benefit clinical practice.

Preceptorship of PAs as Improvement Measure

AAPA also supports the proposed new Improvement Activity titled, “Provide Education Opportunities for New Clinicians,” for QPP year 2 and future years. In the proposed measure, MIPS eligible clinicians in community practices in small, underserved or rural areas may act as preceptors for clinicians-in-training, including PAs, for credit toward their Improvement Activity MIPS score. The self-education and improvement that occurs from serving as a preceptor has an important impact on improved beneficiary care. It’s clear that PA students are having increasing difficulty obtaining clinical rotations. The reason for this is multifactorial and includes increased demands on clinician’s time and a lack of graduate medical education funding for PAs. AAPA believes incentivizing a clinician to serve as a PA preceptor will help meet the continued educational needs of the next generation of PAs. However, AAPA encourages CMS to expand eligible preceptor sites to metropolitan areas, hospitals and health systems in order to make this Improvement Activity accessible to the broadest possible array of clinicians and to have a stronger impact on the quality of education provided to students.

Topped-Out Measures

CMS has proposed to remove topped-out quality measures if a “measure performance is so consistently high that meaningful distinctions and improvement in performance can no longer be made,” and proposes a three-year timeline for removal of such measures. AAPA appreciates this current proposed timeline as it makes health professionals aware of any potential removal of measures sufficiently in advance. If health professionals rely on measures that will soon be removed, a three-year timeline will permit them to begin preparation to switch which metrics they use for MIPS participation. We also support the option of public comment for final determination of removal of a topped-out measure, as opposed to automatic removal. However, AAPA believes CMS should take into account many aspects before final removal of a topped-out measure, such as whether a metric’s consistently-high scores are merely a result of the incentives. There may be some measures that are so important for patients’ health that they should be maintained to incentivize continued compliance. In addition, AAPA is

concerned the removal of too many topped-out measures could diminish reporting options for some clinicians.

Virtual Groups

AAPA is pleased CMS has provided details regarding the MIPS virtual group reporting option. CMS proposes that solo practitioners or practices of less than or equal to 10 MIPS ECs can join other solo practitioners or groups of less than 10 to form a virtual group. Health professionals must state in advance their intention to form a virtual group, and each participating clinician will participate for the entire performance year in only that virtual group. Virtual groups are established with a required written agreement, and any changes in information must be updated with CMS. AAPA has reviewed the policies regarding virtual groups and has the following observations.

- CMS indicated low-volume threshold determinations will be made at the individual/group level, and not at the virtual group level. This means if a solo practitioner or small group does not exceed the MIPS low-volume threshold on their own to be able to participate in MIPS, they cannot participate in a virtual group. Consequently, solo practitioners cannot use participation in the virtual group to exceed the low-volume threshold and qualify for MIPS. As small groups are more likely to be able to exceed the low-volume threshold outside of the virtual group than a solo practitioner, AAPA believes this policy is disproportionately restrictive to individual health professionals. AAPA recommends that instead, CMS permit solo practitioners, who do not exceed the low-volume threshold on their own, the option to join a virtual group (should the group agree) as another method of opting in to participate in MIPS.
- CMS specified that virtual groups are achieved through the combination of tax identification numbers (TINs). Consequently, virtual groups cannot be formed with select members from one group with select members of another. Instead, a solo practitioner, or an entire group, must commit to the virtual group. AAPA understands the intention of this requirement to simplify reporting. However, we also foresee potential scenarios where this may be unduly prohibitive. Elsewhere in the proposed rule, CMS suggests sub-groups may be formed to report independently of the group at large, for example, under a multi-specialty group. A specialty subgroup may find that, due to their arrangement, it may be in their interest to participate in a virtual group. Further, groups that have decided their health professionals will report individually may have practitioners that wish to take advantage of the economies of scale, but are unable to do so.
- CMS signified that, although there is a limit on the size of a group that can join a virtual group, the agency will not initially be capping the size of the virtual group itself. Consequently, it is possible that a large number of solo practitioners and small practices may join together to make an extremely large virtual group. AAPA understands the desire to not cap participation in any one group before further analysis can be performed regarding the appropriate cap level and effects of a cap, but suggests that CMS keep an eye on potential unintended consequences, such as reductions in competition if virtual groups become large, especially in small- to medium-sized communities.

- CMS proposed that, contrary to the suggestions of the Act, virtual groups will report on all four categories together. AAPA approves of this, as it will simplify the logistics of reporting if data on all four measure categories is aggregated and reported by the same entity, instead of reporting on two categories through the virtual group, and two externally. As a result, this will also simplify virtual group feedback reports.
- CMS proposed that virtual groups be required to re-register each year. AAPA understands the rationale behind this requirement. However, AAPA recommends that CMS seek ways to simplify the process for those virtual groups that wish to resubmit with minimal changes to their staff or written agreement.
- Finally, AAPA is pleased CMS has stated it will offer virtual group-specific technical assistance. The virtual group concept is new and quite complicated and will certainly elicit a high level of uncertainty and misunderstanding. AAPA recommends that CMS determine methods to provide technical assistance to individuals considering joining a virtual group, individual members of a virtual group, and to the virtual group once it has formed.

Bonus Points

Performance Improvement Bonus Points

AAPA appreciates the opportunity for clinicians to earn bonus points for performance improvement under the MIPS Quality and Cost categories. As part of determining performance improvement in Quality, CMS will need to assess improvement at the category level, since quality measures may change over the years. Regarding Cost, AAPA appreciates CMS' intent to include a list of cost measures for a given performance period in annual rulemaking, so clinicians know which measures will be used in the cost performance category. We also approve of capping the amount of improvement bonus points one can receive in a given year, preventing a significant leap over other consistently high performers, while still providing an incentive to improve.

Complex Patients Bonus Points

AAPA supports a final score bonus for “complex patients.” [Studies](#) demonstrate that PAs care for the same patient medical complexity as physicians. In addition, PAs often practice in areas where there are physician shortages and where patients often have high medical complexities due to a multitude of factors, including psychosocial risk factors, health illiteracy, and resource constraints. Providing a “complex patients” bonus will help discourage health professionals from selecting or “cherry picking” only the least complex patients in order to achieve better outcomes and scores.

Small Practice Bonus Points

CMS proposes to apply a final score bonus for “small practices,” and solicit comments as to whether there should be a similar bonus for “rural practices.” As many PAs practice in small and rural practices, AAPA is in favor of bonus scores for both small practices and rural practices to encourage clinicians to work in these settings. Clinicians in small and rural practices often have fewer resources to help achieve quality measures (e.g. nutritionists, therapists, specialists, etc.) than clinicians in larger, urban groups

and settings. In addition, patients in small and rural practices may have more barriers to self-care (e.g. distance from clinical care, access to technology and patient portals, etc.) than patients in areas with more resources, thus reducing their ability to comply with quality measures.

Physician-Focused Payment Models

AAPA appreciates CMS' continually evolving interpretation of Physician-Focused Payment Models. In the 2017 QPP Final Rule, CMS clarified health professionals other than physicians may propose and participate in Physician-Focused Payment Models. In the 2018 QPP proposed rule, CMS has sought to amplify the impact of Physician-Focused Payment Models again by suggesting that their focus be expanded beyond Medicare to programs such as Medicaid and Children's Health Insurance Program. AAPA approves of this expansion, but continues to believe the title should be provider neutral.

The ability of any health professional to submit a potential model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) is an acknowledgement by CMS that it holds no monopoly on inventive payment models for testing. The process of identifying and implementing creative care delivery solutions should not be confined to Medicare if efficiencies can be identified under other programs and additional stakeholders can be engaged. AAPA supports the increased scope of Physician-Focused Payment Models and suggests that CMS ensure that there exists a sufficient infrastructure under the PTAC review and recommendation system to accommodate the likely increase in submissions that may pertain to the new programs and models of care.

Conclusion

PAs are responsible for providing hundreds of millions of patient visits each year. They are an essential part of the healthcare delivery system. PAs must be able to fully participate and be recognized in the QPP. Anything less will mean that the information contained in reported metrics and outcome measures, as well as in Physician Compare, will be inaccurate and decisions made based on that erroneous data will be inherently flawed.

AAPA appreciates the agency's consideration of our comments and looks forward to a continued working relationship with CMS to ensure the best possible care for all Medicare beneficiaries. If you have any questions about our comments or concerns please do not hesitate to contact Michael Powe, AAPA vice president of Reimbursement & Professional Advocacy at 571-319-4345 or michael@aapa.org. Sincerely,



Jennifer L. Dorn
Chief Executive Officer