



November 16, 2015

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave., SW  
Washington, DC 20201

Attention: CMS 3321- NC

**Comments to the CMS Request for Information, Merit-based Incentive Payment System and Promotion of Alternative Payment Models**

The American Academy of Physician Assistants (AAPA), on behalf of the more than 104,000 certified physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments to CMS regarding the Medicare Access and CHIP Reauthorization Act (MACRA) Request for Information (RFI) surrounding implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APMs), and incentive payments for participation in eligible APMs. We applaud CMS for reaching out to, and soliciting input from, affected stakeholders. We trust that our response will provide the agency with information and perspective on this extremely important subject which impacts PAs and the patients they serve. It is within that context that we draw your attention to our comments. For your convenience, we have divided our comments according to topic.

**Transparency and Practitioner Recognition**

One of the overarching themes surrounding MIPS is the importance of data. The accurate, systematic gathering and analysis of data is an essential part of any attempt to move from a fee-for-service to a fee-for-value healthcare system in which quality, resource allocation and patient satisfaction play an increasingly meaningful role.

We know that the timely and effective use of clinical data has the potential to transform many aspects of how healthcare is delivered, measured, reimbursed, and improved. One factor, however, that has the potential to emphatically impede the effective utilization of data is populating data sources with information that is either incorrect or incomplete.

If the premise of MIPS and other health-related programs that seek to use evidence-based, quality- driven information to guide clinical practice and evaluate performance is to gather data that is an accurate reflection of the actual care that is being provided, then CMS must find a solution to the problem of “hidden” healthcare services. PAs and advanced practice nurses play an essential role in delivering care to patients in virtually every specialty and practice setting. Yet a substantial percentage of the services provided by those health professionals are not submitted under their name or national provider identification (NPI) number and consequently not attributed to the actual provider of care.

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” if Medicare’s more restrictive reimbursement rules are followed. When services delivered by PAs are legally billed under the name of the PA’s collaborating physician as an “incident to” service, the PA’s name and NPI typically does not appear on the claim form. This means that the actual provider of care is not identified. Elimination of “incident to” billing as it applies to PAs and advanced practice nurses is a way to resolve this problem and ensure that all health professionals are visible.

How can information about quality performance or resource utilization at the individual health professional level be considered accurate when reporting systems fail to identify the health professional who actually delivered the care? In addition, programs such as MIPS may establish low volume thresholds to excuse those professionals from participation if they treat a small number of eligible patients. PAs might be in a situation in which they treat a high volume of eligible patients, but because a substantial number of those patient visits are billed under the physician, they may show up in the system as providing a low volume of care. That “low volume designation” could cause a PA to be excluded from participation in programs such as MIPS and Physician Compare hindering their ability to qualify for incentive payments or to demonstrate the high quality care that they deliver.

If CMS fails to address this critical and fundamental issue, then CMS’ data gathering processes will be flawed and eligible health professionals could be excluded from, or have limited access to, participation in CMS programs that are a vital part of the move to value-based healthcare delivery.

### **Ensuring Patient Access to Care**

As CMS moves forward with a number of programs and initiatives aimed at improving quality and increasing practice efficiencies it is essential that the concept of inter-disciplinary, team-based care be at the forefront of those programs, regulations and practice guidelines. A high performing, coordinated healthcare system recognizes the unique education, skill set and competency of each health professional in order to enhance patient care quality and increase the likelihood of positive clinical outcomes.

Rules and regulations that artificially limit the participation of qualified health professionals, such as PAs, only serve to create barriers to patient care and reduce access. Quite simply, PAs should be authorized and incentivized to practice to the full extent of their education and expertise in all current and future care models. Language that is physician-centric as opposed to provider neutral and policies that fail to acknowledge the capacity of PAs to practice medicine are counterproductive and will constrain America’s healthcare system from achieving its goals of improving care quality and increasing patient access to care.

### **The Merit-based Incentive Payment System (MIPS)**

*Responds to Questions:*

- *Should we maintain the same or similar reporting criteria under MIPS as under the PQRS?*
- *We seek comment on what additional data integrity requirements should be in place for the reporting mechanisms referenced above.*
- *What should CMS require in terms of testing of the qualified registry, QCDR, or direct EHR product, or EHR data submission vendor product?*
- *What feedback from CMS during testing would be beneficial to these stakeholders?*

One major modification to provider evaluation and reimbursement that was established in MACRA is MIPS, a program that intends to assess total performance through a composite score that will result in a payment adjustment. This singular composite score will be based on assessment of quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record (EHR) technology and will replace the current Physician Quality Reporting System (PQRS), the Value-based Modifier (VM), and Meaningful Use (MU) as of January 1, 2019.

As noted in AAPA's response to the 2016 Physician Fee Schedule, we recognize that the upcoming transition to MIPS finds value in the simplification of the incentive process through consolidation. However, in response to many of the questions posed in the MACRA RFI, AAPA would like to stress a set of additional standards we consider essential. First, AAPA encourages CMS to utilize the next three years to properly transition the existing incentive programs so that the eventual conversion to MIPS is seamless, and reporting activities can remain relatively consistent. Second, data transmission for reporting for MIPS should be straightforward, as personalized as possible, secure with a validation process allowing professionals to know that data sent has been received, and a method to identify whether there are missing fields or duplicative submissions.

Finally, CMS should take a managerial, but relatively unobtrusive role by being only as involved as necessary to promote quality, affordable, and innovative care. One such role CMS should play, as queried in the RFI, is to test quality data submitted to CMS, reviewing them for interoperability, and ensuring the inclusion of necessary data fields. Clear feedback to submitters on data submission as to whether appropriate standards were met, where submission may have fallen short, communication on whether minimum requirements were met, and suggestions for improvement will help ensure timely, appropriate and complete data submissions to establish a MIPS composite score. If data submissions do not meet established CMS standards at the time of official data transmission, there should be a timely notification by CMS and a sufficient amount of time allowed for rectification prior to a penalty being assessed.

**We believe that data transmissions should be simple, personalized, secure, and supportive of the inclusion of necessary data. Finally, AAPA supports a role for CMS that is directorial but undisruptive to include testing sample submissions and providing clear feedback in a timely manner.**

AAPA's remaining comments on MIPS have been divided by sub-topic.

#### Clinical Practice Improvement Activities (CPIAs)

##### *Responds to Questions:*

- *How should the various subcategories be weighted? Should each subcategory have equal weight, or should certain subcategories be weighted more than others?*
- *What information should be reported and what quality checks and/or data validation should occur to ensure successful completion of these activities?*
- *How often providers should report or attest that they have met the required activities?*
- *Should performance in this category be based on demonstrated availability of specific functions and capabilities?*

The MIPS composite score will be comprised of an assessment of performance regarding 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, Clinical Practice Improvement Activities (CPIAs), does not.

CPIAs will be comprised of six categories, with the specific measures in each that are yet to be determined. Those six categories are 1) expanded practice access, 2) population management, 3) care coordination, 4) beneficiary engagement, 5) patient safety, and 6) participation in an APM. AAPA believes that these categories generally encompass the metrics that are necessary to determine CPIA performance.

As mentioned in AAPA's comments to the 2016 Physician Fee Schedule proposed rule, we believe that what makes the CPIA category unique and potentially valuable is its stated intention to result in improved outcomes. Specific metrics included under this component should therefore demonstrate efforts that go beyond what is expected, and potentially beyond what is currently incentivized, in order to demonstrate innovation and best practice. AAPA recommends that the proof of such endeavors comes in the form of both an attestation, as well as the submission of data to support claims of improvement activities. Some examples of metrics that can be used to determine practice improvements include the implementation and use of mechanisms (e.g., portals) for patient/provider interaction, whether additional medical conditions are acquired by patients as a result of care they received in an office or facility and mortality rates.

Reporting itself could be performed every six months with any adjustments made annually, allowing health professionals the opportunity to react to one set of feedback reports from CMS before being rewarded or penalized. Another way in which CMS can reduce unwarranted penalties is to only include metrics for CPIA reflecting activities that are within the scope of practice of all eligible professionals (EPs). If an EP is unable to perform the activities needed to achieve a higher score, then the health professional may be unfairly punished for scope of practice restrictions, for example, or narrow metrics that are beyond their control. For metrics that eventually become common practice, unnecessary, or for which improvement beyond an already achieved advanced level becomes unduly burdensome, such measures should be removed from consideration of improvement activities and either be eliminated, or included under quality measures if now a generally accepted practice.

**We recommend that activities under CPIA represent innovative and best practice activities that are flexible in nature and geared to the appropriate specialty of the respective EP. AAPA proposes that proof of meeting such requirements can take many forms, including attestation, and should be as reasonable as possible while maintaining the ability to have such proof authenticated.**

#### Meaningful Use of Electronic Health Records (EHRs)

##### *Responds to Questions:*

- *Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?*
- *Should the performance score for this category be based solely on full achievement of meaningful use?*

AAPA is supportive of the appropriate use of EHRs due to their potential to simplify processes, automate tasks, provide patients with access to their health information and capture essential health data. We realize that CMS will maintain a strong focus on the meaningful use of EHRs going forward, not only as one of the four MIPS components, but also as a requirement for APMs. AAPA believes that proper use of Health Information Technology (HIT) is woven into the MIPS program generally, and consequently must have standards to ensure comprehensive data capture, accurate calculations, and appropriate transmission of data. However, we also recognize that comprehensive implementation will take time.

AAPA recommends that CMS initially adopt a tiered methodology that reflects the relative level of achievement attained by the health professional for meeting meaningful use (MU) standards, as opposed to defaulting to an "all

or nothing” rating methodology. Even those health professionals who may have utilized EHRs for some time may not have had prior experience in reporting on its use. Some health professionals, such as many PAs, have not been included in previous MU incentive programs.<sup>1</sup> Consequently, some health professionals may start at a disadvantage when compared to others. A tiered assessment of achievement will provide time for providers to demonstrate that they are making significant strides in using EHRs

### **AAPA approves of a tiered methodology to reflect levels of achievement of MU standards.**

#### Flexibility in Data Submission for Four Categories

##### *Responds to Questions:*

- *Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category? If so, how should we account for the percentage weight that is otherwise applicable for that category? Should it be evenly distributed across the remaining performance categories? Or should the weights be increased for one or more specific performance categories, such as the quality performance category?*
- *Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP?*

Throughout the MACRA RFI, CMS mentions the possibility of some professionals being unable to meet the requirements of MIPS due to circumstances beyond their control. AAPA agrees with this assessment as some professionals, by virtue of their specialty or medical responsibilities, may be unable to effectively meet a sufficient number of measures through no fault of their own. These limitations are unavoidable in a one-size-fits-all approach. However, AAPA cautions against exempting classes of providers from the requirement of reporting on certain components. Instead, when any of the established MIPS components do not properly reflect care provided by a health professional, AAPA recommends that CMS provide further flexibility in what measures may be used to report on that component, and even allow for a possible change in the component’s scoring weights. We believe that a different set of measures could be justifiable, but allowing different providers to report on different general components (quality, value, improvement, and use of HIT) may prove more difficult. Consequently, AAPA suggests that CMS allow provider groups themselves to provide the solution, allowing affiliated associations to apply for reporting modifications and even propose new and supplemental measures to be approved and used by CMS if it can be shown that health professionals are having difficulties with existing measures.

**AAPA requests that CMS refrain from exempting providers from entire MIPS components, but instead allow for classes of providers who are unable to respond to a minimum number of metrics to propose their own for supplement, or even allow for adjustment to component scoring weights.**

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<sup>1</sup> The Centers for Medicare and Medicaid Services. Eligibility. Accessed November 2, 2015. <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/eligibility.html>

Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas (HPSA)

*Responds to Questions:*

- *What kind of support should CMS offer in helping providers understand the requirements of MIPS?*
- *Should there be conditions of participation and/or exclusions in the providers eligible to receive such assistance?*
- *Should such assistance require multi-year provider technical assistance commitment, or should it be provided on a one-time basis?*

As indicted in the MACRA RFI, the Secretary can enter into contracts and agreements to offer guidance and technical assistance to MIPS EPs in practices of 15 or fewer professionals. Priority is given to small practices in rural areas, HPSAs, medically underserved areas, and practices with low composite scores.

AAPA approves of consideration being given to small practices in rural areas and HPSAs and would also encourage lower thresholds for certain measures for providers in these settings. PAs know firsthand the challenges of delivering care in underserved and rural communities as approximately 21 percent of PAs practice in rural areas.<sup>2</sup> The challenges to reporting, in many practice settings, include financial issues, administrative time, infrastructure, and an understanding of the program requirements. These challenges can be further magnified in rural practices. AAPA would support the creation of educational emails and webinars, personal assistance, as well as guidance and access to already existing resources that seek to ameliorate the difficulties experienced by these underserved practice locations. Outreach efforts may be modeled on CMS' recent ICD-10 campaign to encourage an understanding of substantial policy changes.<sup>3</sup> Support provided should focus on not only walking through what must be done to successfully report, but also consist of a continued dialogue between such underserved locations and CMS regarding other obstacles that make reporting difficult. CMS ought to cast a wide net in its support efforts, working with practices as long as they can demonstrate a need for assistance. The agency should direct and prioritize resources to those practices with the greatest need, but not seek to exclude other practices from access to technical assistance.

**AAPA supports the concept of technical assistance provided to small practices, as well as lower thresholds for these health professionals. We believe that such professionals would be further aided by a continued dialogue with CMS regarding obstacles and challenges they encounter.**

<sup>2</sup> American Academy of Physician Assistants. 2013 AAPA Annual Survey Data Tables. Accessed November 2, 2015.

<sup>3</sup> The Centers for Medicare and Medicaid Services. Provider Resources. Accessed November 2, 2015.

<https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>

## Feedback Reports

### *Responds to Questions:*

- *With what frequency is it beneficial for an EP to receive feedback? Would there be value in receiving interim reports based on rolling performance periods to make illustrative calculations about the EP's performance?*
- *What types of information should we provide to EPs about their practice's performance within the feedback report?*
- *Would it be beneficial for EPs to receive feedback information related to the clinical practice improvement activities and meaningful use of certified EHR technology performance categories?*

AAPA is a strong supporter of sufficient communication between the agency and healthcare professionals to encourage success. The provision of feedback reports to providers helps clinicians better understand CMS' expectations and allow providers to make corresponding improvements. As such, AAPA recommends that CMS provide feedback reports to health professionals at a frequency that allows professionals to make necessary adjustments before monetary penalties occur (e.g., on a quarterly basis). Timeliness of feedback, based on the most recent data available, can provide medical professionals the opportunity to quickly rectify a potential negative score. Feedback after the reporting period ends does not allow for health professionals to take corrective actions.

The content of the feedback reports should include an indication as to whether the requirements were met, to what extent, and if not, why. CMS may also find it beneficial for such reports to include recommendations for improvement and explanations of how any changes will affect a professional's reimbursement. Feedback should be provided on all four components on which a professional is assessed under MIPS.

**AAPA recommends that feedback reports be provided to health professionals on at least a quarterly basis in order to allow professionals to make necessary adjustments before monetary penalties occur and be based on the most recent data available. We encourage CMS to provide feedback on all four components, make these reports available through a secure web site or portal, and include information on a health professional's current status and provide opportunities for improvement.**

## Alternative Payment Models (APMs)

A second major focus of MACRA is to encourage the participation of health professionals in APMs through incentive payments, exemption from MIPS, and support for "physician-focused payment models." AAPA finds great value in team-based, coordinated approaches to care such as those incentivized by many APMs. We recognize the benefits that APMs can provide to the system and to patients in the form of increased access to high-quality and cost-effective care.

The fact that payment in APMs is based on similar measures/metrics as compared to MIPS measures is a positive that should provide an easier transaction for health professionals going from one program to the other. In order for a health professional to be eligible to claim that s/he is participating in an APM and therefore, not required to participate in MIPS, the professional must receive a minimum percentage threshold of payments received from APMs. Beginning with a requirement of 25 percent for 2019 and 2020, then 50 percent in 2021 and 2022, and finally 75 percent thereafter, this stepwise rise will allow for a more manageable adjustment by providers who may not have prior experience in this model. AAPA also appreciates the flexibility provided by the additional classification of 'partial QPs,' for those who meet slightly lower percentage thresholds and subsequently do not get the incentive, but are also exempt from MIPS should they choose to opt out. This secondary category would allow more providers to pursue APM participation with less fear of not reaching the pre-determined APM thresholds.

MACRA established an independent 'Physician-focused Payment Model Technical Advisory Committee' to review and provide comments and recommendations on submitted physician-focused payment models (PFPMs). AAPA appreciates the intent of these models and stresses that such models should be both inclusive of all appropriate types of health professionals and distinguish themselves from existing payment models. CMS should encourage those stakeholders that present models to the committee to indicate what the new model will test and demonstrate that the care model is truly innovative. In addition, AAPA recommends an adjustment to the name of such models, from 'physician-focused payment models' to 'practitioner-focused payment models,' in order to convey a more inclusive notion of who may operate within them.

**AAPA is supportive of APM quality and EHR requirements that are reasonably comparable to MIPS and agrees with the gradual increase in threshold for consideration as an APM QP. However, AAPA requests that when determining thresholds CMS give consideration to the fact that certain policies do not allow for the comprehensive recognition and tracking of PAs. Finally, AAPA recommends that PFPMs be inclusive of PAs and other health professionals recognizing the need for an inter-disciplinary approaches to care and that PFPMs should have their name changed to 'practitioner- focused payment models' or another term that is not so physician centric and acknowledges that there are different types of healthcare professionals delivering necessary care to patients.**

### Conclusion

PAs stand ready to work with CMS, other health professionals and stakeholders in facilitating the transition to MIPS and APMs to achieve the goals of improving the quality of care provided to patients while creating efficiencies that use efficiencies to slow the growth in healthcare spending. We believe that only way for that transition to occur is through transparency and the full recognition of PAs and other health professionals who are vital to the care delivery team.

We appreciate the opportunity to provide feedback on the MACRA RFI. AAPA welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. For any questions you may have in regard to our comments and recommendations please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or [michael@aapa.org](mailto:michael@aapa.org).

Sincerely,



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President and Chair of the Board