



June 27, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-5517-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: File Code-CMS-5517-P; Medicare Program; Merit Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule; and Criteria for Physician-Focused Payment Models**

The American Academy of PAs (AAPA), on behalf of the more than 108,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on *the Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models* proposed rule. The PA profession acknowledges that changes are necessary to improve the manner in which healthcare is delivered and financed in this country. We believe that the transformation to a value-based payment methodology has the potential to achieve improvements in care quality, patient experience and treatment outcomes at a lower per capita cost to the healthcare system. PAs are committed to increasing access to quality healthcare services and we seek to work in partnership with the Department of Health and Human Services (HHS) and CMS in both the development and implementation of innovative policies that help achieve that goal.

The Medicare Access and CHIP Reauthorization Act (MACRA) created both the Merit-based Incentive Payment System (MIPS), as well as the concept of advanced Alternative Payment Models (APMs), collectively known as the Quality Payment Program (QPP), to act as dual tracks for value-based reimbursement. AAPA appreciates the enhanced level of interaction that CMS has sought from the healthcare community regarding innovative payment concepts through the MACRA Request for Information (RFI) process, soliciting comments on the MACRA proposed rule and numerous CMS-led conference calls and listening sessions. We are also pleased to see certain directives in the proposed rule that move toward increased flexibility and simplification in terms of how health professionals will be required to report information to CMS such as the:

- reduction in the number of clinical quality measures that must be reported,
- availability of more than 90 options for reporting clinical practice improvement activities, and
- ability of health professionals to determine the most meaningful measures on which to report as part of the Quality Reporting program.

At the same time, the new payment concepts being proposed represent a dramatic departure from the current payment system and will lead to significant and complex changes for health professionals and the administrative infrastructure of practices, facilities and health systems. A comprehensive and systemic change of this magnitude requires adequate time to prepare and educate numerous levels of stakeholders. Under the present timelines, appropriate education and preparation cannot occur. AAPA has major concerns with the short timeframe allotted between the issuance of the final QPP regulations, likely in the fall of 2016, and the start of the MIPS data collection process in January 2017. AAPA strongly encourages a minimum 6-month delay to the start of the QPP program and believes that a 12-month delay is preferable. It is crucial that CMS actively and appropriately involve PAs and other health

professionals at every step of the QPP implementation process if CMS expects for the transition to be successful.

CMS must remain mindful of the fact that the entire purpose of value-based payments should be aimed at achieving significant and lasting improvements to patient care, patient satisfaction and the lowering of long-term costs. Simply putting forth an array of complicated reporting requirements and mandates will not necessarily lead the healthcare system toward that goal. In addition, the more time health professionals spend checking boxes, documenting activities and trying to navigate a reporting system that may not meaningfully lead to better patient outcomes the more disillusioned they will become. PAs, physicians and other health professionals want to improve the level of care provided to patients. Policies and programs implemented by CMS must facilitate and complement that objective.

We believe our comments will provide the agency with information and perspective on this extremely important subject and how it impacts PAs and the patients they serve. It is within this context that we draw your attention to our comments regarding MACRA and the QPP.

## **Accurate Recognition of Health Professionals**

### Transparency & Accountability

AAPA finds merit in the transition from fee-for-service to reimbursement based on value. Assessments about the value of care are dependent on the accurate gathering and analysis of representative data on quality, performance, resource allocation, and patient satisfaction.

However, these potentially promising payment system reforms that seek to assess value and outcomes, and reimburse accordingly, are likely to be fundamentally flawed when determining which professionals qualify for inclusion, the assigning of composite scores and the listing of health professionals on the Physician Compare website due to the unintended lack of recognition of certain health professionals, such as PAs, through the existing claims processing system. **Quite simply, PAs will not be able to fully participate in the QPP program if their services to Medicare beneficiaries are not properly recognized.**

In the transition to both MIPS and Advanced APMs it will be essential to ensure that CMS policies do not undermine the accurate reporting of information and metrics for the new QPP program. Under certain circumstances, the Medicare program has a payment and reimbursement policy that has the effect of hiding the health professional who delivered 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 represent or identify the actual provider of care.

Many aspects of the new QPP are dependent on accurate data, especially regarding determination of health professional eligibility for participation in MIPS. While PAs are considered eligible clinicians (ECs) under MIPS, this does not guarantee program participation. To maintain eligibility, PAs, physicians and advanced practice nurses must exceed a “low-volume threshold,” which for MIPS means having more than \$10,000 in Medicare billing charges or providing care for more than 100 unique Medicare Part B-enrolled beneficiaries. PAs might be in a situation in which they treat a sufficient volume of eligible patients, but because a substantial number of those patient visits are billed under the physician, they may show up in the CMS claims system as not having provided or billed for the requisite number of services and, therefore, be considered as falling below the threshold. As long as PAs have the potential to be hidden providers, the threshold will be a problem and the work performed by the PA will be

inappropriately assigned to the physician who did not personally perform the service. If CMS intends to create similar incentive programs or measure sets under Medicaid, this situation is only compounded as ten states (20 percent) do not accept their NPI on claims, contributing further to the hidden provider problem.

The inability to accurately capture which health professional is providing a specific service causes additional problems beyond prohibitive eligibility determinations. Health professionals, based on data captured through MIPS and APM reporting, will have participation and performance information posted on CMS' Physician Compare website, a publicly facing resource through which patients may seek and compare and choose health professionals. As a result of inaccurate information collected via claims as to who provided care, this site will misrepresent PA-provided care and quality, and potentially mask the services performed by some PAs all together. Omitting a practitioner from the Physician Compare site may give the false impression to patients that an otherwise available health professional in their community is not an option from which to receive care thus decreasing access.

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 and appropriate provider attribution. The first step to ensuring all health professionals are visible would be to eliminate the problem created by "incident to" billing by requiring the name and NPI number of the rendering provider (i.e. PA) be included on all "incident to" claims.

**For purposes of accountability and in keeping with the desired implementation concepts 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 electronic claim submission. 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 and would not change the payment amount or the fact that payment is made to the PA's employer. It simply brings greater transparency to the overall healthcare delivery process and allows PAs to appropriately meet the guidelines and requirements of the QPP.

In addition, CMS should encourage Medicaid programs and private insurers, whose data may impact whether health professionals in an Advanced APM entity meet the QP threshold through the 'all-payer/other payer' combination option, to enroll PAs for the purpose of including their name and NPI on claims for services provided.

#### Provider Neutrality

The MACRA proposed rule calls attention to the issue of how the QPP is designated. We have issues with the terminology "physician-focused payment models" used to describe MIPS and APMs. Utilizing such physician-centric language instead of the more preferable and inclusive "provider-focused payment models," indirectly gives the impression of marginalizing other health professionals. If, in fact, the goal is to move toward a team-based care model in which every health professional delivers patient care to the full extent of their education and expertise, then every effort should be made to recognize the wide range of health professionals who are part of the team. While we understand that the term "physician-focused payment models" comes from statutory language, in other parts of the rule terminology has been changed such as moving to the term Eligible Clinicians instead of Eligible Professionals, or the renaming MIPS/APMs under the rubric of the new term QPP.

**Language, regulations and policies that are physician-centric, as opposed to provider neutral, run the risk of placing exclusions or artificial limits on the participation of qualified health professionals, such as PAs, and only serve to create barriers to patient access to care.** At a point in time where more individuals are seeking care, combined with the looming physician shortage, we

encourage CMS and all state and local policy makers to be more inclusive and to recognize that we need to adopt an “all hands on deck” mentality as the nation seeks to expand access to timely medical care.

## **Medical Home Model & Primary Care Focus**

In the proposed rule, CMS states that it believes that an APM cannot be a Medical Home Model unless that APM has a primary care focus with an explicit relationship between patients and their practitioners. AAPA understands and supports that concept. The proposed rule goes on to discuss the designation of health professionals who are considered eligible clinicians within this model. PAs with the specialty code 97 are included among the list of health professionals deemed to be eligible clinicians for the Medical Home Model. AAPA supports the full inclusion of PAs who practice in primary care in the medical home model.

**As PAs practice in all medical and surgical specialties there may be a need to assure that those only PAs who practice in primary care be eligible for the Medical Home Model. This can be easily accomplished by having PAs self-attest to the fact that they practice in primary care. Those PAs who do not practice in primary care would be ineligible to participate. This would be similar to the self-attestation process physicians, PAs and APNs utilized with the Medicaid Parity program that increased Medicaid rates for primary care services delivered to Medicaid beneficiaries.**

## **Reporting Simplicity and Flexibility**

AAPA’s assertion in its comments to CMS’ 2015 MACRA Request for Information (RFI) that the new MIPS and APMs tracks be as straightforward and as personalized as possible for each health professional makes clear our organization’s preference for simplicity and flexibility. Consequently, we are pleased CMS included many opportunities to enhance the simplification and flexibility of reporting for health professionals in this proposed rule.

### **Flexibility under MIPS**

AAPA applauds the fact that CMS proposes many activities that emphasize flexibility. First, CMS offers the ability to report and be assessed as either an individual or as part of a group under MIPS. Second, likely in response to many of the comments proposed by the provider community, CMS reduces the number of measures required to be reported under certain categories, such as a reduction to six measures for quality reporting as opposed to the nine required under PQRS.

Third, for those measures that are required to be reported, CMS proposes to allow health professionals a certain degree of flexibility in which metrics to choose so that they may select ones that best represent their practice. For example, allowing health professionals to choose from more than 200 measures for quality reporting, either individually or part of a pre-packaged set, and allowing professionals to choose from more than 90 activities when reporting on clinical practice improvement activities.

It is also beneficial that CMS intends to post quality measures online annually for public input, and plans to consult Eligible Clinician (EC) groups regarding the development of quality measures prior to posting. AAPA strongly suggests that CMS meet with groups representing all types of ECs in order to receive a comprehensive set of perspectives and input.

In the proposed rule, CMS makes an effort to address lessons learned from the Meaningful Use program for its new “Advancing Care Information” category that measures adoption and use of electronic health records (EHRs). First, health professionals such as PAs, who were largely excluded from previously participating, are welcome to eventually be assessed by this category. In addition, CMS provides health professionals multiple paths to receive a full score when reporting on Advancing Care Information and

allows an extra year to transition to Stage 3 requirements for Certified EHR Technology (CEHRT). Finally, in AAPA's comments to the MACRA RFI, we recommended a rejection of an 'all or nothing' scoring methodology, and are pleased to see that CMS agreed. However, AAPA is concerned that more may need to be done to allow health professionals to be successful regarding Advancing Care Information due to the fact that some health professionals did not operate under the Meaningful Use program, and among those who did, many were not successful in reaching its lofty benchmarks.

One method in which CMS attempts to mitigate these concerns is by allowing certain types of health professionals to be exempt from categories, reducing the relative weight of a category to zero, and increasing the weights of the other three categories. Regarding Advancing Care Information specifically, while AAPA noted in its comments to the RFI that health professionals such as PAs who did not participate in the Meaningful Use program may be at a disadvantage when compared to others, we also explicitly indicated that exempting classes of health professionals from entire categories could set an undesirable precedent.

AAPA agrees that 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. However, AAPA continues to caution against exempting classes of providers from the requirement of reporting on whole categories. **Instead, when any of the established MIPS categories 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 in that category, and even allow for a possible change in the category's scoring weights.** We believe that a different set of measures could be justifiable, but allowing different providers to report on different general categories may prove more difficult and administratively complicated. 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.

#### Flexibility under APMs

AAPA approves of many of the flexibility proposals for the Advanced APMs track. The concept of Partial Qualified Practitioners (QPs) that allows those entities unable to meet the percentage threshold for full QP status, but do meet a slightly lower threshold to attain a compromise position of optional exemption from MIPS but without the APM incentive, is appropriate. Many health professionals in APM entities may be interested in transitioning to be QPs, but may not be successful in initially changing the entities patient composition. Providing this intermediate status will make CMS' desired migration from MIPS to Advanced APMs more likely by making the transition less daunting. In this vein, AAPA is also in favor of CMS' requirement for comparable quality measures between MIPS and Advanced APMs as this will provide reasonable continuity of evaluation for health professionals hoping to transition from one track to the other.

Finally, CMS' alternative option for achieving QP status, which in 2021 allows for Advanced APM entities that are trying to meet QP thresholds to take into account patients covered by non-Medicare payers (such as Medicare Advantage plans), may provide further flexibility.

While CMS has made efforts to increase flexibility, AAPA reminds that going forward, it will be important to continue such efforts, adapting to feedback and seeking to implement best practices that align public and private payers in these efforts.

## **Feedback Reports**

In AAPA's comments to the MACRA RFI, we recommended feedback reports on a quarterly basis. However, CMS has proposed to begin by providing such reports annually. We reassert our concern that

an annual feedback report would not allow for corrective action and again recommend quarterly feedback based on the most recent data. This would allow professionals to make necessary adjustments to be in alignment with CMS QPP requirements.

AAPA continues to be a strong proponent of ongoing regular communication between CMS and health professionals for the benefit of both practitioners and the program. The provision of feedback reports to providers helps clinicians better understand CMS' expectations and allows providers to make corresponding improvements. Just as important as the frequency of feedback reports is their content, CMS has proposed to initially only report on the MIPS 'quality' and 'cost' categories. We strongly recommended that feedback be provided on all four categories on which a health professional is assessed under MIPS.

Only providing feedback to half of what a health professional is being assessed on hampers the ability to improve in those categories for which no feedback is given. The content of the feedback reports should include an indication as to whether the requirements were met in each of the four categories, 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.

**To the credit of CMS, the agency did acknowledge broad stakeholder support for more frequent feedback reports, as well as reporting on all four categories, and left the option open to changing to such policies in the future. AAPA recommends that such policies be implemented at the outset, as the initial years of the program may be the time in which frequent and comprehensive feedback is needed the most.**

## **The Two Year Data Delay**

In the MACRA proposed rule, CMS has proposed a two year delay between the time data is collected and the time when the payment adjustment for this data occurs. Consequently, the first year in which the pay adjustment will take place, 2019, will utilize data based on the performance of health professionals in 2017. AAPA joins other stakeholders in the provider community in having serious concern for this two year lag time. With a two year delay between assessment and payment adjustments, there is virtually no opportunity for corrective actions. By the time the first pay adjustment is made, data that will determine the next year's adjustment will have already been submitted.

**AAPA recommends that the first payment adjustment year be based on data collected in 2018.**

This will allow for more time to prepare and implement the significant changes proposed by CMS. 2017 could still be the first year for which data is submitted, but the first year could be used as a test for reporting mechanisms and processes, identifying potential pitfalls, and allowing feedback to act as a learning experience for health professionals and CMS alike. This would be similar to the implementation of ICD-10 when there were no financial penalties in the first year of the program if health professionals demonstrated a basic level of compliance to the rules of the program. AAPA would then be in favor of a similar one year gap between data reporting and reimbursement going forward. Logistically, data would be collected throughout 2018, with reimbursement provided to health professionals in mid-2019. For 2019, data would be collected throughout the year, followed by the corresponding adjustment in mid-2020, and so forth. We believe that having reimbursement more closely correspond to the time period which an adjustment represents increases the relevancy of any penalty or reward.

## **Education of Affected Health Professionals**

As currently proposed, the assessment of health professionals under the Quality Payment Program is scheduled to begin in January 2017, which will be an incredibly short period of time after CMS finalizes the rule's operational policies. As was mentioned earlier, such a quick turnaround may make the

appropriate implementation of the rule impossible for many practices and health professionals, but at a minimum underscores the importance of a robust and far-reaching education plan that can be implemented immediately after the final rule is issued to ensure that affected health professionals are aware of those QPP policies that stand to directly impact them.

AAPA is concerned about the successful implementation of such an education plan in this small window of time. The rule, beyond its sheer length, is overflowing with information about a system that is very different than what health professionals have encountered before. AAPA is concerned that the rule's level of complexity may cause errors or omissions in reporting and requirements, or in extreme cases consolidation as a result of difficulty for small practices to keep up. We believe that this accentuates the importance of CMS' proposed technical assistance to MIPS ECs in practices of 15 or fewer professionals. AAPA approves of consideration being given to small practices in rural areas and HPSAs. PAs know firsthand the challenges of delivering care in underserved and rural communities as approximately 21 percent of PAs practice in rural areas. 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. Support provided should focus on not only adjudicating 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 ongoing technical assistance.

Our participation in recent webinars has further stoked this concern regarding whether health professionals will be sufficiently and appropriately informed on the Quality Payment Program before assessment begins. On multiple webinars CMS officials presented slides and accompanying narrative contrary to our interpretation of the proposed rule itself in regard to PA participation in the Advancing Care Information category of MIPS. While presenters seemed to emphasize the "exclusion" of PAs from this category, in fact the proposed rule is not exclusionary. Here is the language from the proposed rule:

"Because many of these non-physician clinicians are not eligible to participate in the Medicare and/or Medicaid EHR Incentive Program, we have little evidence as to whether there are sufficient measures applicable and available to these types of MIPS eligible clinicians under our proposals for the advancing care information performance category. The low numbers of NPs and PAs who have attested for the Medicaid incentive payments may indicate that EHR Incentive Program measures required to earn the incentive are not applicable or available, and thus would not be applicable or available under the advancing care information performance category. For these reasons, we propose to rely on section 1848(q)(5)(F) of the Act to assign a weight of zero to the advancing care information performance category **if there are not sufficient measures** applicable and available to NPs, PAs, CRNAs, and CNSs. We would assign a weight of zero **only in the event that an NP, PA, CRNA, or CNS does not submit any data for any of the measures** specified for the advancing care information performance category. **We encourage all NPs, PAs, CRNAs, and CNSs to report on these measures to the extent they are applicable and available**, however, we understand that some NPs, PAs, CRNAs, and CNSs **may choose to accept a weight of zero** for this performance category if they are unable to fully report the advancing care information measures. We believe this approach is appropriate for the first MIPS performance period based on the payment consequences associated with reporting, the fact that many of these types of MIPS eligible clinicians may lack experience with EHR use, and our current uncertainty as to whether we have proposed sufficient measures that are applicable and available to these types of MIPS eligible clinicians. We note that we would use the first MIPS performance period to further evaluate the participation of these MIPS eligible clinicians in the advancing care information performance category and would consider for subsequent years whether the

measures specified for this category are applicable and available to these MIPS eligible clinicians.” (**Bold** emphasis added)

We are pleased to note that after some discussion CMS officials acknowledged the mischaracterization and changed their interpretation to what we believe to be the correct one. AAPA believes that such discrepancies in interpretation, coupled with the overall complexity of the rule and its proposed transition, gives emphasis to the need for a coordinated and ongoing educational initiative. We suggest this may continue to include a combination of calls, webinars, personal assistance, and FAQs, with the opportunity for health professionals to submit inquiries directly to CMS regarding implementation of the QPP provisions. Educational materials should include scoring examples, specialty-specific tools, and resources personalized to practice areas and practice types. **AAPA recommends CMS utilize all educational methods that were employed in conveying the details of the transition to ICD-10, and continue to work with relevant stakeholder medical societies and partners, such as AAPA, in order to educate stakeholders. Finally, educational efforts should continue well beyond the date of implementation to address ongoing questions, concerns and difficulties.**

AAPA appreciates this opportunity to provide feedback on the MACRA proposed rule on the Quality Payments Program and 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,

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

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