September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1654-P
200 Independence Ave., SW
Washington, DC 20201

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 proposed rule; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model (CMS-1654-P)

Dear Administrator Slavitt,

The American Academy of PAs (AAPA), on behalf of the more than 108,500 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 proposed rule. PAs are authorized to provide medical and surgical care to Medicare beneficiaries 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 thoughtful policies that help in achieving that goal.

As healthcare in this country trends toward increased transparency and more efficient care delivery models for beneficiaries, this proposed rule includes provisions aimed at enhancing precision in payment, improving the accuracy of data collection regarding which health professional is providing care and expanding care options and choices for Medicare beneficiaries. AAPA is mindful of the potential benefits of certain provisions proposed in the rule, but believes any program or policy that is ultimately enacted must be designed and implemented in a manner that is not unduly complex or disruptive to patients or to the health professionals who care for them. It is within this context that we draw your attention to our comments regarding CMS' planned modifications to the Physician Fee Schedule for 2017.

Provisions Regarding Precision in Payment

Collecting Data on Resources Used in Furnishing Global Surgical Services

Congressionally mandated language in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires CMS to develop a process to gather information needed to determine the value of surgical services and requires the data collection begin no later than January 1, 2017. The collected information must include both the number and level of medical visits furnished during the global period and other items and services related to the surgery.

In the proposed rule, CMS proposes a multi-faceted methodology to collect timely and accurate data on the frequency of, and inputs involved in furnishing, global surgical services including the procedure itself and the pre-operative visit(s), postoperative visits, and other services for which payment is included in the global surgical payment bundle.

The data collection efforts would involve the following:

(1) Comprehensive claims-based reporting about the number and level of pre- and postoperative visits furnished for 010- and 090-day global services.

(2) A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks.

(3) A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

CMS' proposal to collect the pre- and post-operative visits included in the global surgical bundle by reporting newly created Healthcare Common Procedure Coding System level II G codes is dubious and likely not to capture the specificity of data that the Agency expects. We remain concerned about the difficulty in educating health professionals as to the use of an entirely new set of "evaluation and management" codes, juxtaposed with the existing E/M codes that have been in use for decades and that will continue to be used for patient care services not related to the surgical bundle. It will be difficult to avoid confusion with the use of two sets of codes that describe similar types of services.

The thought of recording time spent per patient, at the minute level, which is another part of the CMS proposal, for every task that a health professional and their clinical staff perform throughout the day is simply inconceivable. By mandating that codes be billed in 10 minute increments, professionals will be burdened to both learn the reporting requirements of these new codes, while also monitoring their time in 10 minute increments. The net result can only be a loss of quality time with patients and a frustrating administrative hassle for health professionals and their staff.

CPT code 99024 which is described as: *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* represents the most rational coding method to identify the number of post-operative visits associated with a surgical procedure.

AAPA understands and appreciates the goals of determining appropriate levels of reimbursement for surgical services, but we stress that any future modifications to the current system should not be carried out in a way that penalizes health professionals. For example, a previous CMS proposal to separate the post-operative payment from the global surgical bundle was potentially problematic in that there could have been an unfair lowering of the reimbursement made for first assisting services which is paid at a percentage of the global package. AAPA approves of a continued search for payment validity and fairness, and recommends the consideration of fair-minded compensation be kept in mind to avoid penalizing any health professionals due to the "law of unintended consequences" as this collection and evaluation process moves forward.

AAPA believes (1) there should not be an automatic assumption that services within the global surgical bundle are necessarily misvalued or incorrect from a volume standpoint; and (2) there is a clear need to balance the accurate gathering of data in order to make an appropriate determination with the very real concern of not unnecessarily disrupting the ability of health professionals to deliver care to patients. CMS must not underestimate the extraordinary amount of professional time and administrative burden that its current proposal will require from surgical practices throughout the country. Adding yet another layer of regulatory requirements on top of the overwhelming number of changes related to the shift to value-based reimbursement, such as the Merit-based Incentive Payment System, will take time away from patient care activities at the exact time that more patients are entering into the healthcare system.

Improving Payment Accuracies for Primary Care, Care Management, and Patient-Centered Services

In an effort to improve payment accuracy for primary care, care management, and patient-centered services, CMS is unbundling and separately reimbursing for a number of services, as well as seeking to eliminate administrative burdens. In light of the upcoming transition to the Quality Payment Program (QPP), CMS finds particular value in modifying payment and coding to improve relative value for various services under the Physician Fee Schedule. Specifically, CMS proposes the following:

- Improving payment for care management of beneficiaries with behavioral health conditions (Temporary codes: GPPP1, GPPP2, GPPP3, and GPPPX)
- Improving payment for cognition and functional assessment/care planning for beneficiaries with cognitive impairments (Temporary codes: GPPP6 and GPPP7)
- Adjusting payment for office visits for those with mobility-related disabilities (Code: GDDD1)
- Recognizing non-face-to-face prolonged E/M services that are currently bundled (Codes: 99358, 99359)
- Reducing administrative burden for Chronic Care Management (CCM) through recognition of additional CPT codes for complex CCM (Codes: 99487, 99489), as well as easing requirements for initiating visits, 24/7 access to care and continuity of care, format and sharing of care plan and clinical summaries, documentation, and beneficiary consent/receipt of care

AAPA approves of CMS expanding the number of reimbursable codes to allow health professionals to more accurately report the time, effort, and care provided. We continue to be proponents of proper valuation of codes and appropriate reimbursement for work performed.

AAPA also appreciates CMS' provisions to ease administrative burdens surrounding CCM. After realizing that fewer people received CCM services than anticipated, we appreciate CMS' response to provider feedback that many of the requirements listed were too stringent. We encourage CMS to continue to identify overly complicated and unduly burdensome processes to alleviate unnecessary requirements without compromising standards of quality.

AAPA approves of CMS' expanded coverage of the functions health professionals perform to provide optimal care to patients, as well as the attempts to reduce administrative burdens. We urge CMS to continue to identify and act on further opportunities for appropriate coverage and administrative simplicity.

Provisions Regarding Enhancement of Data Accuracy on Who Provided Care

Provider Enrollment under Medicare Advantage

Currently, Medicare Advantage health plans may include providers and suppliers in their network that are not enrolled in Medicare. As part of its efforts to expand transparency surrounding the delivery of healthcare services, CMS proposes to require health professionals and suppliers under Medicare Advantage who furnish items or services to patients to be enrolled in Medicare meeting CMS guidelines for approved status. CMS indicates that this change will ensure that beneficiaries receive the highest quality care and help reduce waste, fraud, and abuse by preventing unqualified and/or prohibited providers and suppliers from enrolling and being able to treat beneficiaries. AAPA approves of these efforts. However, we seek greater clarification regarding the extent and definition of CMS' required enrollment.

AAPA seeks clarification from CMS as to whether by using the term 'enrollment' they expect providers and suppliers to generically enroll in the Medicare program through the Provider Enrollment, Chain and Ownership System (PECOS), or whether there is an expectation that the individual Medicare Advantage plans will enroll health professionals for the purpose of identifying them as distinctly recognizable health professionals on a claim. If CMS merely intends for health professionals to enroll through PECOS without making it mandatory that a health plan enroll providers and suppliers the agency risks perpetuating the concealment of health professionals such as PAs when a Medicare Advantage plan does not require that such a health professional identify their services, but rather bills for the PA's services under a collaborating physician. When a Medicare Advantage plan requires that a PA bill under a physician, that PA becomes a 'hidden' provider, which works contrary to CMS' goal of proper attribution of services to the health professional who provided the patient care.

Indeed, CMS states in its proposed rule that one of the ways it will safeguard program integrity and care quality is to utilize the ability to take action when a problem is identified. CMS states that it may revoke enrollment for "a network provider with a history of performing medically unnecessary tests, treatments, or procedures," or "a physician who routinely overprescribes dangerous drugs." If any health professional's services continue to be hidden under another's name or provider number, accurate depictions of quality care for both health professionals involved remain imprecise. With improper attribution, determinations of compliance and responsibility will be flawed.

CMS has increasingly demonstrated a desire for greater transparency and granularity of data in recent Medicare rules, including its recent MACRA proposed rule and previous fee schedule rules AAPA believes that CMS should clarify that the proposed requirement for health professionals to enroll extends beyond basic PECOS enrollment and necessitates that health professionals such as PAs be individually enrolled in the respective MA plans. This clarification will advance CMS' goal of transparency by extending the recognition of health professionals on claim forms under their respective name and NPI number.

AAPA supports efforts of greater transparency and accountability to in order to determine which health professional is providing what care. We recommend CMS provide clarification that, to satisfy the objective of CMS' goals of transparency, savings, and accountability, Medicare Advantage plans should be required to enroll relevant health professionals, including PAs, and mandate the inclusion of the appropriate professional's NPI on a claim.

Medicare Shared Savings Program Updates

In the proposed rule, CMS makes many changes to the Medicare Shared Savings Program (MSSP) that would affect reported health data. Three provisions are of particular interest to AAPA:

- As a safeguard for health professionals within a MSSP Accountable Care Organization (ACO), CMS proposes to permit such eligible practitioners to report quality performance category data separately from the ACO, should the ACO not successfully report their quality data for them. Currently, if an MSSP ACO does not report quality data on behalf of their eligible practitioners regarding PQRS, practitioners can separately report data to avoid the PQRS payment adjustment and CMS will use the separately reported data to make determinations about the value-based modifier. CMS plans to carry this policy over when the transition is made to the QPP. AAPA appreciates CMS implementing this policy as a protection against health professionals being penalized due to circumstances that is not their fault. We, like CMS, would prefer for the ACOs to sufficiently report relevant data. However, recognizing that this may not always be the case it is important that eligible practitioners be given the opportunity to guard against any potential penalties from their ACO's data submission oversight or error.

- In order to simplify the eventual transition to the QPP, CMS has proposed to make refinements to the MSSP that would closer align its quality reporting practices and measures with those required under the QPP. AAPA appreciates that CMS is beginning to harmonize programs that will exist concurrently with the QPP. The QPP is one of the most significant restructurings of provider reimbursement in recent history, and as such, will require significant changes and provider education to be successful. The earlier that programmatic coordination can be instituted and properly communicated to affected health professionals, the better. AAPA encourages CMS to incorporate information on changes to existing programs into the robust education campaign we have previously requested of CMS surrounding the QPP so that stakeholders may be able to better adapt their practice and understand the rationale behind any modification.

- CMS proposes to modify its existing algorithm that assigns beneficiaries to a particular ACO. This modification would allow a beneficiary to designate an ACO professional as primarily responsible for their overall care, thereby self-aligning themselves with an ACO through a health professional. CMS indicates that this may increase patient engagement, improve care coordination and health outcomes, and lower expenditures for beneficiaries. While AAPA approves of providing greater flexibility for beneficiaries to choose their own care, we recommend that, just as health professionals should be sufficiently informed of changes to align with the QPP, beneficiaries should be taught about this newfound ability to self-assign and the details for doing so. Allowing an automated direct attestation through MyMedicare.gov/1-800-Medicare/Physician Compare, as opposed to a manual process in which the ACO would have to collect attestations and report, reduces the burden on both health professionals and their ACOs. However, this underscores the importance of a comprehensive and accurate listing of health professionals on websites such as Physician Compare from which beneficiaries may select.

  AAPA is further concerned regarding the terminology of selecting a "main doctor." We believe that, since ACO attribution has been associated with the provider of primary care services, CMS should explicitly clarify that any of those health professionals allowed to act as a beneficiary's primary care provider, including PAs, should be allowed to be chosen. The term "main doctor" should be changed to a broader term, such as "main health practitioner," and be consistently used in this manner on all implementation and outward facing materials.

AAPA appreciates CMS' policy to allow for health professionals to separately report data in the instance that an ACO does not report for them. We request clarification of the logistics of such reporting once the QPP is in place. AAPA also appreciates efforts to harmonize the MSSP with the forthcoming QPP, which emphasizes the need for proper education on such unification efforts. However, while AAPA approves of CMS' proposal to allow patients to self-identify, we believe that this provision underscores the need to make sure that selection locations such as Physician Compare include a comprehensive list of available health professionals for patients to select. CMS should also modify any physician-centric language to indicate that a primary care provider, such as PAs, can be selected by the patient.

Provisions Regarding Patient Access

New Telehealth Codes

Pursuant to Medicare Transmittal #1885, dated May 16, 2003, Medicare law allows PAs, physicians and certain other healthcare professionals to be reimbursed for providing telemedicine services to patients. CMS continues to expand those services that it determines are eligible to be provided remotely.

In the 2016 Physician Fee Schedule, CMS proposed the addition of six codes related to prolonged inpatient care and End-stage Renal Disease (ESRD). The 2017 Physician Fee Schedule proposed rule builds on previous code enhancements by adding several new codes that would be eligible for the telehealth benefit. The new telehealth codes fall under three primary categories:

1) *ESRD-related Services for Dialysis*

   Following the addition of ESRD-related services for dialysis in the 2016 Physician Fee Schedule, CMS has added four additional ESRD codes (90967-90970) by claiming they are sufficiently similar to those approved last year. AAPA approves of CMS' expansion of ESRD codes that can be provided via telehealth, as well as the general process used of identifying already-approved codes as a "template" for approving other services that are similar in nature.

2) *Advanced Care Planning Services*

   In AAPA's response to the 2016 Physician Fee Schedule Proposed Rule, we expressed our support for the potential of Advanced Care Planning Services and for discussions with patients regarding advanced directives. We are pleased that CMS has recognized the value of providing these services (CPT codes 99497 and 99498) via telehealth. AAPA was also pleased that in the 2016 Physician Fee Schedule CMS made explicit that the ability to perform Advanced Care Planning services extended beyond physicians to 'qualified health professionals' such as PAs. We would be remiss if we did not point out that if PAs are authorized to discuss end of life care preferences with Medicare beneficiaries it would naturally follow that they ought to be able to order, provide and manage hospice care services for those same beneficiaries. The Medicare program's rules for hospice care coverage currently does not give that ability to PAs despite the fact that PA education and expertise fully qualify them to order, deliver and manage hospice care.

3) *Critical Care Consultations*

   Telehealth consultations for a patient requiring critical care services will now be able to be submitted using two new G-codes: GTTT1 (60 minutes communicating with the patient via telehealth – initial) and GTTT2 (50 minutes communicating with the patient via telehealth – subsequent). While AAPA supports CMS' decision to allow for critical care consultations to be

provided via telehealth, we are concerned that the addition of yet more G-codes may provide an additional educational burden, especially since CMS has already proposed to add a significant number of G-codes to the fee schedule as part of the Global Services Data Collection process.

AAPA favors the use of telehealth in as robust a manner as possible while maintaining the highest care quality. Delivery of care through telehealth can be particularly advantageous to patients who have severe illnesses that compromise their ability to travel and for patients in rural locations for which travel to obtain certain specialty and/or tertiary care would be costly, time consuming and logistically challenging.

AAPA applauds CMS' ongoing consideration of new opportunities for providing telehealth services and specifically the inclusion of these three new services. AAPA believes there continue to be many services of value to patients that can be performed via telehealth and encourage CMS to continue to explore options for care that can be safely and effectively provided via telehealth to the benefit of patients. However, we also reiterate that since PAs are allowed to provide Advanced Care Planning in order to discuss end of life preferences, it would follow that PAs should also be permitted to order, provide and manage hospice care.

Expansion of the Diabetes Prevention Program Model

In the rule, CMS proposes to expand the Diabetes Prevention Program, a treatment care model that includes dietary coaching, lifestyle intervention and physical activity, for Medicare beneficiaries beginning January 1, 2018. The goal of this program expansion is to prevent the onset of diabetes in pre-diabetic individuals by producing an average weight loss of at least five percent among beneficiaries. The program consists of sixteen intensive sessions, followed by monthly follow-up meetings.

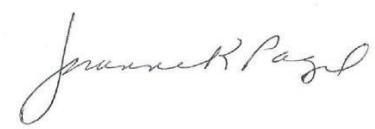
AAPA finds value in expanding these types of preventive public health programs that seek to prevent the inception of disease and illness before they occur. We believe that incentivizing appropriate care that leads to the improved health status of patients represents a sustainable long-term, cost-saving strategy. When primary care health professionals, such as PAs, are authorized to proactively treat patients and are encouraged to help patients make good choices as opposed to simply delivering care after an illness is present, both the healthcare system and patients stand to benefit. AAPA encourages CMS to continue to identify effective programs for expansion that create program efficiencies by bolstering patient access to preventive health services.

AAPA welcomes the expansion of the Diabetes Prevention Program Model into Medicare and would support other similar programs that have proven effective at creating efficiency by fostering health.

AAPA appreciates the agency's consideration of our comments and looks forward to working 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,



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