



April 24, 2017

Dr. Patrick Conway
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

RE: Episode-Based Cost Measure Development for the Quality Payment Program

Dear Dr. Conway,

The American Academy of PAs (AAPA), on behalf of the more than 115,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the *Episode-Based Cost Measure Development for the Quality Payment Program (QPP)* report. AAPA welcomes CMS' efforts to seek meaningful input from the health professional community and other interested stakeholders into the development of cost measures as part of QPP. AAPA has participated in recent CMS listening sessions on this issue, and we value the CMS outreach to health professionals, including PAs, regarding potential participation on clinical subcommittees that will assist in determining some of the technical details of episode groups, trigger codes, and other aspects of cost measure development. We believe that regular opportunities for the public and health policy stakeholders to provide comments encourages an ongoing discussion that allows new and significant policies, like those being implemented under the QPP, to adapt and improve. AAPA encourages CMS to continue to find additional opportunities for stakeholder engagement as the QPP is evaluated and refined.

AAPA understands CMS' goal to identify accurate metrics of a health professional's resource use so that those metrics can be paired with quality measures, and assessments of value of care can be made. However, we caution that the actual development and implementation of such measures is extremely complex and, if not done properly, can lead to inaccurate data collection and erroneous conclusions. AAPA is particularly concerned about the effects of current policies on CMS' gathering of cost data, as well as a continued lack of clarity surrounding the mechanics and use of the resource cost information.

Existing Policy Unfavorable to Cost Data Collection Efforts

Billing Mechanisms

In the report titled, "Episode-Based Cost Measure Development for the Quality Payment Program," CMS assigns five essential components to the building of cost measures:

1. Defining an episode group
2. Assigning costs to the episode group
3. Attributing the episode group to one or more responsible clinicians
4. Risk adjusting episode group resources or defining episodes to compare like beneficiaries
5. To the extent possible, aligning episode groups with indicators of quality

Many of these essential components were developed or affirmed out of previous stakeholder comments received from CMS on the issue. For example, CMS' stakeholder input cited in the report indicated that "Attribution of episode groups to clinicians should be clear and credible," and "The information provided by cost measures should be actionable and timely," which can directly be seen to have influenced component three (attributing the episode group to one or more responsible clinicians). CMS further expounds, "The cost category of MIPS provides an opportunity for informing clinicians on the costs for which they are directly responsible, as well as the total costs of their patients' care," and, "We intend for the information on cost to be actionable by clinicians in targeting areas for improving the delivery of high-value care and resulting in smarter spending and improved patient outcomes and experience."

AAPA concurs with CMS' numerous affirmations of component three, and believes accurate attribution of services to the appropriate health professionals is in the interest of transparency, accountability, and the potential to drive beneficial change in the system, as well as to reward those who are delivering high quality, cost-effective care. However, we find the existence of "incident to" billing within Medicare threatens the stated objective of this component. Billing mechanisms such as "incident to" force health professionals who are considered Eligible Clinicians (ECs), specifically PAs and nurse practitioners (NPs), to be "hidden providers," with all or some of their personally provided services billed to and attributed to another health professional who may not have been involved in a particular patient care encounter. When health professionals are "hidden providers" the data collected is not accurate and the feedback reports may not go to the health professional who personally delivered the care.

If a health professional's services are hidden under another professional's name and National Provider Identification (NPI) number, accurate depictions of quality of care or resource utilization for both health professionals will be imprecise. With improper attribution, collected data will be incorrect and determinations of resource use will necessarily be flawed. In 2014, Medicare's Provider Utilization and Payment Data public use file, or the so-called "Medicare data dump," provided a concrete example of the detrimental effects of billing mechanisms such as "incident to" on data collection activities. Public review of the information elicited shock at the revenue of some physicians, provoking some to question how this was possible. The answer in many cases was that some services provided by other health professionals, such as PAs, were being captured under the physician's name and NPI number, biasing the data and effective comparisons, while also obscuring some or all of the work done by PAs and NPs. CMS should make every effort to prevent this same spurious data collection problem from impacting data gathered as part of the QPP.

Concerns regarding “incident to” billing extend beyond a potential biasing of cost data to other aspects of the QPP as well. Other examples include whether a health professional, such as a PA, reporting individually, will be deemed as a QPP low-volume threshold professional and what information will appear on the health professional’s Physician Compare profile. In addition, improper data obscuring a health professional’s true output can affect not only their MIPS score, but also influence future employment pursuits if a potential employer chooses to evaluate and factor in MIPS scores in their hiring decisions.

As part of determining cost allocation, CMS will have to decide how resource cost responsibility will be divided among different health professionals who treat a patient during the same episode of care. Currently, CMS has suggested the concept of identifying health professionals as the “direct” vs. “indirect” provider of care, depending on the type and level of care delivered. We are interested in seeing additional clarity regarding how that distinction is made. The conceptual framework for “direct” and “indirect” providers may offer some insight in addressing the problem of “hidden providers.”

Restrictions on Range of Treatments

An essential function of the anticipated cost measures is to allow comparability of resource use between health professionals for similar patients and clinical scenarios. However, any comparison between physicians and PAs or NPs from a resource utilization (and outcome) perspective may well be flawed. Currently, CMS restricts PAs and NPs from ordering diabetic shoes, medical nutrition therapy, and home health and hospice services, despite the fact that PAs and NPs are qualified by education and training to order and/or perform these same services. Health professionals who are restrained by CMS regulations in the care they can provide will be compared to physicians who are able to deliver a more comprehensive set of services to similar patients.

For example, take a situation in which a PA is treating a diabetic patient in a clinic that is located in an underserved community, physically remote from the PA’s collaborating physician. The patient suffers from diabetes mellitus, has diabetic neuropathic foot ulceration and needs diabetic shoes to prevent the formation of additional ulcers. Since current Medicare coverage policy does not authorize PAs (or NPs) to order diabetic shoes, that patient will have to find a physician (who has never treated the patient and is not familiar with that patient’s medical history), travel to the physician’s office (which may be a logistical challenge) in order to have a physician order diabetic shoes. The longer a patient waits for diabetic shoes the greater the risk of the formation of additional calluses, foot ulcers, and even the potential of toe or foot amputation. This is clearly detrimental to the interests of the patient, and will certainly drive up the total cost of care for no logical reason except for outdated and irrational coverage policies that limit the provision of medically necessary care. CMS should eliminate such barriers to care, giving patients timely access to needed services which produce the highest quality outcomes, while also ensuring that comparisons between health professionals are accurate and fair based on their ability to provide the full range of necessary care to patients.

Conclusion: Needed Clarifications

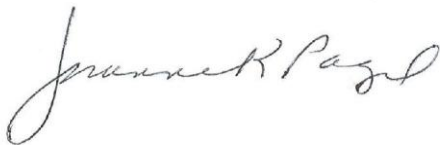
AAPA is concerned that a lack of clarity from CMS regarding certain policy specifics of the forthcoming cost measures may lead to confusion detrimental to health professionals and the healthcare market at large. AAPA requests further public clarification from CMS regarding the specifics of how its cost measures will be both developed and used in the assessment of health professionals and their cost-category score. AAPA requests greater transparency surrounding the expected role of patient-relationship codes (themselves still requiring greater refinement and clarity), the role of episode groups, how the various components fit together, which types of actions by health professionals will affect a practitioner's score, and what type of information will appear in feedback reports.

While CMS has slowly revealed more about the various components that will make up the MIPS cost measures, a clear depiction of the complete product remains shrouded. AAPA recommends further elucidation and greater clarity regarding the "big picture" be provided before CMS' first anticipated feedback report.

AAPA is also concerned there may be continued confusion among health professionals surrounding the issue of comparability of health professionals based on patients, episodes and risk adjustment. We perceive that there exists a persistent interpretation that someone who provides services that incur more costs (e.g., referrals to specialists or imaging services) will be disproportionately penalized due to the increased cost of patient care. Consequently, AAPA requests that CMS clarify the important point that there is nothing inherently wrong with ordering additional services if that's what is required in the specific context of doing what is best for the patient. Rather, it is the comparative assessment, that is, how a health professional's ordering, referring and treatment costs compare to those of other health professionals with similar patients and clinical scenarios that matters.

AAPA appreciates this opportunity to provide feedback on the Cost Measure Development report 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.

Sincerely,



Josanne K. Pagel, MPAS, PA-C, Karuna RMT, DFAAPA
President and Chair of the Board