



January 16, 2018

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

RE: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 123,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program proposed rule. We would like to draw attention to one provision in the proposed rule which deals with transparency in the Medicare Advantage (MA) claims and billing process. We believe that the objective and rationale for increased transparency, which we support, can only be fully achieved when the Centers for Medicare and Medicaid Services (CMS) addresses the claims and billing procedures surrounding medical services delivered by PAs and nurse practitioners (NPs). This is an issue that impacts both the MA and fee-for-service programs under Medicare.

On page 56452 of the Federal Register, CMS proposes to codify a program requirement that Part C patient encounter data submitted to the agency by a Medicare Advantage (MA) organization must include the billing provider's NPI on each MA encounter data record. This effort is aimed at enhancing CMS' ability to appropriately assign risk adjustment payments. It will also aid CMS in identifying individuals or entities who would be subject to the CMS new preclusion list - health professionals currently revoked from the Medicare program due to inappropriate prescribing activities or whose behavior would lead to revocation due to their prescribing activities. Consequently, CMS is modifying its regulatory language in favor of greater data specificity on attribution, in order to maintain program integrity and increase the accuracy of policy assessments.

AAPA agrees with the principle of collecting precise attribution data in order to make correct policy assessments. We believe that CMS collecting data from payers and providers that accurately attribute

care and services to the appropriate health professional is a concept that should extend beyond the inclusion of a billing NPI on Part C risk adjustment data. If this principle is extended to Part B data collection, CMS would be able to benefit from more informed policy assessments under traditional Medicare as well as MA. Therefore, AAPA requests that CMS fully adopt the principle of billing and claims transparency and address the issue of health professionals, such as PAs and NPs, being relegated to hidden provider status under Medicare fee-for-service due to billing scenarios, for example, that utilize “incident to.”

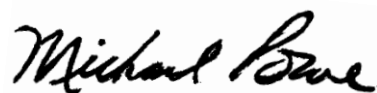
Under Medicare’s current claims processing system, the care provided by PAs and NPs is often attributed to physicians through use of “incident to” billing. PAs are essentially “hidden providers” when this occurs. This means that any payment system that seeks to collect data to make important policy decisions is likely to collect data that is fundamentally flawed due to imprecise attribution. This will then have policy implications in instances such as the collection of attribution data for quality and cost assessment, which will ultimately affect provider reimbursement. The concern regarding the effect of “incident to” billing on value-based programs, such as the Quality Payment Program, has recently been echoed by the [Health Affairs Blog](#) in a January 8, 2018, posting.

Data-driven insights are dependent on accurate information that attributes the care provided to the appropriate health professional. AAPA suggests that CMS mandate that the name of the health professional that actually rendered patient care be listed and trackable in the Medicare claims system, even when billing occurs under the “incident to” provision. We would be more than happy to offer solutions to resolve this issue with minimal disruption to the Medicare claims processing system.

Both Medicare Part C, as well as Part B, would benefit from correct attribution data for decision-making and addressing the issue of “incident to” billing will ensure accuracy as data becomes even more important to Medicare decision-making and program analysis. This modification would also reaffirm CMS’ commitment to the principles of program integrity, transparency, accountability, and trust in the precision and completeness of its data.

Thank you for the opportunity to provide feedback on this aspect of the Medicare Advantage Proposed Rule. AAPA welcomes the opportunity for further discussion with CMS regarding our positions and comments. 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 and Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

A handwritten signature in black ink that reads "Michael Powe". The signature is written in a cursive, flowing style.

Michael Powe
Vice President, Reimbursement and Professional Advocacy