September 10, 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; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability 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 Center for Medicare and Medicaid Services' (CMS) 2019 Physician Fee Schedule and Quality Payment Program rule.

PAs and the patients they serve will be greatly affected by the proposed modifications to reimbursement policies made under both the Physician Fee Schedule and the Quality Payment Program. These effects will be magnified as the PA profession continues to play an increasingly important role in the healthcare delivery system providing hundreds of millions of patient visits each year. It is within this context that we draw your attention to our comments.

Proposals Related to the Physician Fee Schedule (PFS)

Modifications to Evaluation and Management (E/M) Reimbursement and Documentation

CMS proposes significant changes to the methodology in which E/M visits are reimbursed, as well as to Medicare requirements for medical record documentation for office-based E/M visits. AAPA has serious concerns with these changes. AAPA strongly supports the CMS initiative "Patients Over Paperwork." We believe the goal of reducing administrative burdens for PAs and other healthcare professionals and allowing them to devote more time to patient care is a positive step. Some of the proposed changes to the documentation requirements demonstrate that CMS listened to the concerns of practicing clinicians regarding the significant level of administrative burdens associated with the current documentation. We are grateful for CMS' efforts to simplify these requirements and reduce their associated red tape. But other facets of the E/M proposal are worrisome and will require a great deal of additional discussion and elaboration by CMS regarding the conceptual framework, feasibility of the proposed changes and the timing of implementation.

The American Medical Association has established a twelve-person work group to review the current coding and documentation requirements for office-based E/M visits with the goal of simplifying the work of healthcare professionals and improving the health of patients. AAPA strongly urges CMS to delay plans to consolidate or "collapse" E/M office-based codes or to change the existing E/M payment structure until this work group has completed its analysis and provides direct input to CMS. The work group represents numerous medical specialties and includes a PA ensuring broad participation of the medical community.

- *E/M Reimbursement: A Proposed Single Payment Rate for Levels 2 Through 5*

In the proposed rule, CMS unveiled a plan to consolidate the various payment rates for E/M levels 2 through 5 to single payment rates for new and established patients, with the potential of utilizing add-on codes to reflect situations when additional resources are used. AAPA recognizes there may be some perceived benefits of the proposed "blended" payment rate such as a reimbursement system that could pay primary care providers more for services they deliver. The single payment rate may also simplify the processing of claims by CMS. However, there are numerous potential negative consequences to this proposed policy.

AAPA's chief concern is the potential effect of this proposed policy on patients. We expect the single payment rate may incentivize some health professionals to "cherry pick" patients who are healthier and of a lower complexity in order to be paid the blended rate for less time consuming, and potentially a higher volume of, patient visits. This may exacerbate access to care issues for the most vulnerable patient populations. AAPA is also concerned the single payment rate may lead to some professionals spending less time with complex patients who they agree to take on, due to the reduced rate reimbursed for such visits. In extreme cases, this reduced time and attention may worsen patient conditions and exacerbate costs to the program derived from this population, which is already a chief driver of high health costs. AAPA is also concerned by the perverse incentive created by the single payment rate for some health professionals who seek to maximize their reimbursement by requiring patients to schedule additional visits if multiple medical issues are presented. Requiring patients to return for additional visits, in addition to exploiting the single payment rate, would be an inefficient usage of patient and provider time, leading to longer wait times for appointments and worsening access shortages, and requiring patients to pay additional co-pays.

Beyond the effect on patients, AAPA is confident the policy as proposed by CMS will create winners and losers among health professionals. It would be unfair to create a payment system in which health professionals could be financially penalized when they simply want to offer the best quality care to their patients. Compensation not based upon intensity of the service, cognitive difficulty or time and resource allocation appears to not appropriately reward professional work. There is a fairness concern inherent in this methodology. A health professional who treats 15 low-acuity patients per day would earn more in reimbursement as compared to a health professional that treated 10 very complicated patients with multiple comorbidities.

AAPA does not believe the payment concerns stemming from the single payment for Levels 2 through 5 are mitigated through the CMS allowance of add-on codes. These codes are based on the type of provider and not the specific medical needs or co-morbidities of the patient visit. G codes have been proposed to allow for an additional $5 for primary care providers and an additional $14 to be added to services delivered by professionals who work in certain specialties. CMS failed to offer any rationale as to how the specialties eligible for this add-on code were determined. If one looks at Hierarchical

Condition Category (HCC) coding data, specialties that appear to have the most complex patients are not eligible. Of similar concern, PAs do not have a "specialty certification" within Medicare, but do deliver care in all medical and surgical specialties. It is unclear how health professionals such as PAs would "prove" or attest that they practice in one of the eligible specialties.

If this proposal were to go into place as is, significant changes to electronic health records (EHRs) and billing systems would need time to be put in place and a robust education campaign would be required to foster success. However, AAPA suggests providing additional time for analysis, input, and public debate. We are confident, should CMS insist on changing the structure of E/M reimbursement, another option can be developed among a group of affected stakeholders that can achieve similar goals with less confusion and fewer unintended consequences. As a result of myriad concerns AAPA has regarding the E/M single payment proposal put forward by CMS, we strongly recommend any changes to the E/M payment methodology be set aside until more direct input has been received by stakeholders and the AMA's E/M work group.

- *E/M Reimbursement: Eliminating Prohibitions on Same-Day E/M Visits by Professionals in the Same Specialty and in the Same Practice*

CMS suggests the agency is considering eliminating an existing prohibition on reimbursement for same-day E/M visits by multiple practitioners in the same specialty and within the same practice. AAPA is supportive of the removal of this prohibition. While CMS has previously acknowledged the validity of multiple E/M visits provided on the same day within the same practice, the requirement had been for the performing practitioners to be in distinctly different specialties.

With this recommended change, CMS would acknowledge the diversity of subspecialties within specialty classifications. The proposed change would allow patients to seek care in a more logistically efficient manner. For example, patients would now be permitted to complete multiple medically necessary visits without having to return to the practice on a different day. In addition, patients may save time by only filling out new-patient paperwork once. Greater efficiency of time may also extend to the medical professionals who treat patients, as any information required to be shared between health professionals for the sake of coordination of care could occur more seamlessly.

- *E/M Reimbursement: Cuts to Procedure Reimbursement When Provided on the Same Day as E/M Services*

CMS proposes for E/M services and procedures provided on the same date, the reimbursement for the least expensive procedure or visit will be cut by fifty percent. AAPA is concerned this proposed change may create an incentive for health professionals to require patients to come back to receive services they could have received during one trip, thus increasing patient burden, potentially exacerbating access problems, and encouraging inefficiency in the health professional's management of time. AAPA believes the root of this proposed change may lie in a misunderstanding. Specifically, any duplication of resources that occurs when a procedure follows an E/M visit on the same date of service has already been incorporated into the valuation of the procedure that is reimbursed in this scenario by the American Medical Association's Resource-based Relative Value Update Committee. A fifty percent payment reduction would likely cause practices to lose money for this episode of care.

- *E/M Documentation: Health Professionals Would Only Be Required to Document Medical Necessity to Level 2*

CMS proposes to meet Medicare E/M documentation requirements for Levels 2 through 5, a health professional will merely need to document medical necessity to the extent previously required for a Level 2. AAPA appreciates the goal of reduced documentation requirements for Medicare reimbursement. Such a change would allow health professionals to spend more time with patients. We acknowledge that existing E/M documentation requirements may not adequately reflect how health professionals collect, consider and review relevant information about a patient in formulating a diagnosis. However, we question whether the proposed change will actually reduce the need for documentation, as health professionals may need to be more comprehensive than a Level 2 in their documentation to maintain adequate and informative medical records for themselves and other clinicians providing care to patients.

It's also possible for medical liability purposes, due to concerns about malpractice claims, health professionals may need to document above a Level 2, thereby mitigating any true reduction in documentation requirements for reimbursement purposes. If commercial payers do not adopt the same documentation requirements, health professionals, billers, coders and practices could find themselves operating dual medical record documentation systems which will only create confusion and mitigate any intended time savings. Finally, practices, hospitals and health systems have spent millions of dollars purchasing, updating and refining their electronic health records (EHR) systems based on current documentation requirements. Making substantive changes to those EHR systems will be costly in terms of the required financial commitment and the time commitment by information technology personnel and health professionals being educated to meet new documentation standards.

- *E/M Documentation: Eliminating the Requirement to Document History and Exam Information for Established Patients*

The CMS proposal when providing an E/M visit for established patients does not require health professionals to redocument information traditionally identified under the History and Exam portions, but rather only to include relevant information that is new since the last visit. The requirement to repeatedly input previously-captured information would likely be replaced by a new check box that would indicate a health professional had reviewed the information formerly documented and the information is unchanged. AAPA finds value in the concept of reduced clutter. If health professionals were merely copying and pasting previously-gathered information, but now instead are asked to check a box to indicate review, this may save time and even reduce errors. However, AAPA cautions this change may also present pitfalls. As a result of the change, medical decisions going forward will be heavily reliant on information included previously. With the removal of a requirement for repetition, an important tool to verify whether information is current and accurate is diminished.

- *E/M Documentation: Eliminating the Need to Record Information in the Medical Record that has Been Recorded by Someone Else*

CMS proposes to permit health professionals to review and verify information in a medical record, such as chief complaint and history, that was recorded by ancillary staff or the beneficiary, as opposed to requiring the health professional re-enter the information themselves. AAPA supports this concept due to the time it may save health professionals, but we recognize verification of information will require more than a cursory glance by the clinician, as information added by a beneficiary may be less than comprehensive, ambiguous, or even wrong. With other proposed changes in the rule permitting a health professional to no longer collect and redocument information previously collected, errors or incomplete information may be carried forward and could negatively affect future medical decisions.

E/M Documentation: Documenting Teaching Physician Presence During E/M Services

CMS proposes, in certain circumstances, when a teaching physician is present at the provision of E/M services, "the presence and extent of involvement of the teaching physician may be documented in the medical record by a physician, resident, or nurse." In order to provide additional flexibility, AAPA requests PAs be added to the list of health professionals who can document the teaching physician's involvement.

Due to CMS' focus on reducing administrative burdens and improving programmatic and practitioner flexibility, AAPA requests CMS clarify that the documentation of PA students and NP students can be used by teaching physicians in the medical record for billing purposes.

On February 2, 2018, CMS issued a revision to the Medicare Coverage Manual that allowed for greater use of student documentation in a teaching physician's medical record, provided that the teaching physician verifies the documentation. In the past, only the student's documentation of the review of systems and past family and social history did not need to be re-documented.

The revised language in the Medicare Coverage Manual uses the term "student" to describe the documentation that a teaching physician may utilize in the medical record. Chapter 12 of the Medicare Carriers Manual (Rev. 4068, 5-31-18) clearly describes a student as "An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. . ." PA students and NP students should be captured in this definition as they are educated in accredited educational programs that are not approved GME programs.

Despite the language that should be inclusive of PA students and NP students, there remains some confusion about whether the revision to the Medicare Coverage Manual is limited to medical students. CMS should clarify this issue and clearly state documentation from PA students and NP students can be included in the teaching physician's medical record.

Many practicing PAs and NPs precept PA and NP students every day. To ensure access to care for Medicare beneficiaries it is imperative that rules and regulations be structured in a manner that encourages the medical education of this country's future workforce. We believe CMS should revise its regulations in the 2019 Physician Fee Schedule and specifically authorize PAs and NPs to use the documentation of the PA students and NP students they precept in their medical records, similar to teaching physicians.

Finally, in clinical education, students typically first enter a patient's room to perform a history and physical exam. This allows the student to progressively gain the independent experiences he or she will need as a licensed PA, NP or resident physician. The preceptor is always providing appropriate supervision and can enter the room to take over care at any time. The preceptor always reconfirms and personally re-performs the history, physical exam, and medical decision-making services in the physical presence of the patient. We request CMS explicitly include in its sub-regulatory guidance that a preceptor can use appropriately verified student documentation to support an E/M charge if the student first performs the history and examination without the preceptor, then discusses the case with the preceptor outside the patient's room, they both return to see the patient where the preceptor verifies all student documentation in the medical record and personally re-performs the physical exam, and medical decision making services used to support an E/M charge.

New Opportunities for Virtual Care Services

In the 2019 PFS/QPP proposed rule, CMS indicates it will now make small reimbursements for "virtual check-ins." These "virtual check-ins" are intended to be five to ten-minute discussions between a health professional and an established patient. The check in must not originate from a prior E/M visit or lead to an in-person E/M visit. CMS is also proposing reimbursement for a health professional's evaluation of patient-transmitted pictures and videos. Again, the proposal requires the patient be established and the patient's transmission of these photos or videos may not originate from a prior E/M visit or lead to an in-person E/M visit. Finally, CMS is proposing to reimburse for interprofessional consultations in which one health professional requests the opinion of a consulting professional with specialty experience.

AAPA understands CMS does not want these new virtual care opportunities to become methods for supplemental reimbursement, separately payable for services that could be provided/included in a related E/M visit. However, the policy as written constrains the full potential of the convenience of these check-ins to act as follow-up assessments to prior visits, likely saving patients and health professionals time. AAPA supports a re-examination by CMS as to the potential for these services to enhance efficiencies and the patient care experience and asks the agency to reconsider the potential benefit of further modifying the associated reimbursement rules to authorize virtual visits to be used following an E/M visit to prevent, for example, a patient having to make another trip to the health professional's office for an issue that could be safely handled virtually.

Finally, while reimbursement for these services holds great promise in ensuring adequate correspondence between patients and health professionals, as well as between health professionals, in order to reach the full promise regarding access and efficiency of these new options, health professionals such as PAs and NPs must be explicitly permitted to provide these services. Unfortunately, some states may not specifically authorize the use of telehealth/telemedicine by health professionals such as PAs. AAPA suggests CMS issue "best practice" language to states, promoting and encouraging language inclusive of PAs and other appropriate health professionals.

The Relativity Adjuster

In prior PFS rules, CMS has applied a "Relativity Adjuster" to calibrate reimbursement rates for "nonexcepted items and services furnished in nonexcepted off campus provider-based departments." The purpose of the Relativity Adjuster is to equalize payments for select services provided in outpatient settings, and previously reimbursed under the Outpatient Prospective Payment System (OPPS) rate, when those same services are provided in a non-hospital-owned provider office and reimbursed under the PFS. This is done to address concerns of overpayment for services as a result of consolidation from hospitals purchasing previously independent provider offices. CMS proposes to continue to reimburse using a Relativity Adjuster of 40% of the OPPS payment amount under the PFS for nonexcepted items or services in nonexcepted off-campus provider-based departments.

AAPA is pleased that CMS adopted the reimbursement rate of 40% for the Relativity Adjuster, as opposed to the initially proposed 25% for 2018. AAPA recommended a rate of 40% last year until more complete data could be reviewed, in order to ensure adequate payment remained in place. We noted that an overcorrection, which may have led to insufficient compensation of non-excepted off-campus provider-based departments and negatively impacted their ability to provide care, would have been a markedly worse option than the issuance of a higher Relativity Adjuster rate until further data was analyzed. Consequently, we appreciate that, in maintaining this rate for 2019, CMS updated its analysis

to include a full year of claims data from 2017. As a supplemental indicator, we encourage CMS to continue to speak with affected stakeholders to identify additional effects of the reduced reimbursement rate that are not easily monetized in the agency's analysis.

Global Surgery Data Collection

Language in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to develop a process to gather information needed to determine the value of the various components of surgical bundles. Consequently, CMS sought to implement a multi-faceted plan to collect timely and accurate data on the frequency of, and inputs involved in furnishing, global surgical services. CMS sought to identify the breakdown of which resources went into the procedure itself, as well as the pre-operative visit(s), postoperative visits, and other services for which payment is included in the global surgical payment bundle.

In its 2017 PFS final rule, CMS reduced its proposed reporting requirements from an overly burdensome mandate that all affected health professionals would submit a series of G codes to demonstrate 10-minute increments of post-operative global surgical E/M services, to a more manageable method of data collection on this topic. Specifically, the new reporting requirements were aimed at primarily surgical practices in nine states that had ten or more health professionals. CMS asked for information on certain high-volume surgical services and a Healthcare Common Procedure Coding System code became the method of reporting. In the 2019 PFS/QPP proposed rule, CMS explains it has not received a robust data-submission response.

AAPA understands and appreciates the goals of determining appropriate levels of reimbursement for surgical services. However, if CMS does not yet have sufficient data with which to draw conclusions, we suggest it not seek to move forward with modifying the current system until it can base its proposal on robust and accurate data. CMS may improve its collection of this data through efforts to better educate practices in the target states by communicating reporting requirements through state and national medical and surgical associations, as well as seeking voluntary participation from practices that are not located in the targeted states. Only after such additional efforts are made should stricter enforcement be considered, if necessary.

AAPA also stresses any future modifications to the current global surgical payment system should not be carried out in a way that inadvertently penalizes health professionals. For example, a previous CMS proposal to separate the post-operative payment from the global surgical bundle was potentially problematic because there could have been an unfair lowering of the reimbursement for first assisting services which is paid at a percentage of the global surgical reimbursement amount. AAPA approves of a continued search for payment validity and fairness, and encourages CMS to avoid financially penalizing any health professionals due to the "law of unintended consequences" as this collection and evaluation process moves forward.

Proposals Related to the Quality Payment Program (QPP)

Changes to the Low-Volume Threshold

For the 2018 performance period, if an Eligible Clinician (EC) has allowed charges under their name of more than $90,000 under Medicare Part B annually, and furnished services to more than 200 Medicare Part B beneficiaries, that health professional was required to participate in the Merit-based Incentive

Payment System (MIPS). In the 2019 PFS/QPP proposed rule, CMS adds a third component to the QPP low-volume threshold (LVT) for participation: the provision of more than 200 professional services to Medicare Part B beneficiaries. Consequently, if finalized, in 2019 an EC would be required to participate in MIPS only if they exceed all three criteria of the LVT.

AAPA supports the addition of this third criterion to the LVT. The expansion of the LVT likely reduces the number of health professionals *required* to participate under MIPS. However, while CMS is reducing compulsory participants, CMS is concurrently opening MIPS to options of *voluntary* participation.

Under the 2019 PFS/QPP proposed rule, CMS is allowing ECs who meet at least one of the three criteria to opt in to MIPS participation. AAPA similarly approves of this proposal and has expressed concern in previous comment letters at exclusionary language restricting those health professionals who weren't required to participate, but wished to do so voluntarily. The addition of the third component of the LVT will also likely expand the number of health professionals who are now able to voluntarily opt in to MIPS participation by increasing the number of health professionals able to meet at least one of the LVT criteria.

Increases in the Performance Thresholds

CMS indicates it will continue its gradual approach to increasing the point total one must achieve to receive a positive adjustment under MIPS, also known as the performance threshold. In 2019, CMS proposes to set the performance threshold at 30 points out of 100, up from a threshold of 15 points in 2018. Similarly, CMS proposes to increase the exceptional performers threshold, the point total one must achieve to receive bonus reimbursement, to 80 points in 2019, from 70 points in 2018.

AAPA appreciates CMS' approach of gradually implementing higher performance thresholds to allow health professionals time to adapt to a starkly new reimbursement program. However, we also request, as CMS becomes comfortable with the codified expectations under the QPP, it begin to raise the performance threshold to a point total that will reflect the potential positive adjustment identified in the legislative language (soon to be a ± 9%). While AAPA supports a measured approach to increasing reporting requirements and other expectations on clinicians in order to encourage program participation and foster programmatic familiarity, we simultaneously recognize many health professionals are participating in MIPS with the expectation of the possibility of substantive and meaningful reimbursement increases. Unfortunately, high participation numbers, coupled with a relatively low performance threshold, have negatively impacted the incentive payment structure by ensuring that the distribution of money to those who meet QPP benchmarks will be minimal.

Adjustment of the MIPS Cost Category Weight

The Bipartisan Budget Act of 2018 granted CMS flexibility from the original statutory language under MACRA regarding the weights of the various categories under MIPS. While MACRA initially indicated that both Quality and Cost would have a weight of 30% on the MIPS final score in 2019, CMS has been permitted to implement a more gradual increase in the weight of the Cost category. Consequently, for 2019, CMS proposed to set the weight of the Quality category at 45% of the final score and raise the weight of the Cost category to 15%.

AAPA approves of the more gradual increase in the weight of the Cost category as there is still so much unknown about how CMS will utilize cost data, the accuracy in collecting cost data and its effect on

overall reimbursement. We remain particularly concerned with the attribution of care episodes to the appropriate health professional since Medicare's billing/claims process, in certain situations, does not adequately track PA-provided services resulting in an incomplete picture of the volume of care provided by PAs. AAPA continues to encourage CMS to require the name of the health professional who actually provided the care to a patient to appear on Medicare's electronic and paper version claim forms to ensure accuracy and accountability.

The "New" MIPS Promoting Interoperability Category

CMS is proposing to substitute the MIPS Advancing Care Information Category with one titled "Promoting Interoperability" or PI. While it shares a similar focus on electronic health systems as its predecessor, the MIPS PI category removes Advancing Care Information's confusing scoring methodology. Under Advancing Care Information, the scoring system included separate base, performance and bonus scores, allowing an EC to select various measures that together may achieve a passing score. Now, under PI, ECs will be required to report on each of a reduced set of measures that when added together result in a more familiar scoring system based on 100 points. This reduced scoring system measure set will emphasize core objectives such as evaluating, encouraging, and expanding the interoperability of EHR systems.

AAPA appreciates CMS restructuring the previously-confusing scoring system in favor of one more understandable. What may be lost in measure selection flexibility is gained in increased certainty of requirements, with exclusions for those unable to meet the requirements. We also support the increased emphasis on interoperability as this remains one of the largest complications when it comes to effective EHR usage.

AAPA supports the concept of interoperability to improve the efficiency and quality of care delivery, as well as to enhance the patient experience and support care coordination. However, AAPA cautions the benefits of interoperability are diminished if the data or information being transmitted is incomplete or incorrect due to improper attribution. For example, if a provider's office receives a patient's medical record, the information on the record may indicate that care was provided by a physician when in fact care was delivered by a PA. Because of "incident to" billing, for example, the office may be misinformed as to the appropriate health professional to contact with relevant questions, or for the purposes of care coordination. CMS should identify and act on ways to increase data transparency by modifying requirements under billing mechanisms such as "incident to" to ensure that the health professional who actually delivered the care is clearly identified in the patient's medical records and in billing/claims records.

AAPA also cautions for interoperability to be most effective, authorization to fully utilize EHRs and billing systems must be extended to health professionals that deliver medical care. If health professionals, such as PAs, are prevented from fully accessing and utilizing EHR systems, the ability of the health professional to sufficiently provide care that is efficient, safe, and coordinated may be jeopardized.

In the 2019 PFS/QPP proposed rule, CMS also indicates MIPS ECs who participate in the PI category will be required to use 2015 Certified EHR Technology (CEHRT). While we supported previous efforts at flexibility on this matter, AAPA approves of this new requirement. With an increased focus on interoperability, it is appropriate to be sure that offices and systems have the capabilities to meet CMS requirements by which they will be measured and reimbursed. The requirement to have updated CEHRT will also benefit patients due to increased system capabilities.

Finally, CMS informs it plans to continue to provide the same flexibility for PAs and NPs under PI as it did under Advancing Care Information. Specifically, as a result of CMS' uncertainty as to whether PAs and NPs are well-versed with EHRs to participate, reporting for these health professionals will be optional, with an automatic reassignment of score weight to one of the other three categories. AAPA understands CMS' intention and appreciates the continued flexibility up until this point as it sought to further assess PA and NP EHR capabilities. However, we suggest that the expectation now be that PAs and NPs participate fully under PI, with possible exceptions for small PA and NP-owned practices that are unable to afford EHR systems or updated EHR systems. PAs in most practice settings have been using this technology for years, sometimes leading EHR system implementation in the practice, and should be held to the same standards and expectations as physicians. Meanwhile, we encourage CMS to complete its formal assessment regarding PA and NP proficiency with EHRs as soon as possible.

An Increased Number of Opportunities for Reimbursement Under, or Similar to, Advanced APMs

In the 2019 PFS/QPP proposed rule, CMS puts forward several additional opportunities to qualify as an Advanced APM and be exempt from MIPS participation, including all-payer determinations, multi-year determination processes, and the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, which allows practitioners who participate in arrangements under Medicare Advantage that are similar to Advanced APMs to be exempt from MIPS. AAPA approves of these measures as methods to encourage patients and health professionals toward value-based reimbursement and healthcare delivery programs through appropriate incentives, as opposed to an enforced or required transition.

Opportunities for Continued Input on QPP Implementation

While not made explicit in the 2019 PFS/QPP proposed rule, CMS has vocalized numerous opportunities for healthcare stakeholders to participate in advisory positions that may help inform both PFS and QPP policy. One example is the Clinician Champions Program, which seeks to utilize the perspectives of health professionals in determining ways to educate and enhance awareness of the QPP and associated program changes. We encourage CMS to seek diverse professional representation from all affected stakeholders. The inclusion of health professionals, such as PAs, will help inform CMS and other federal agencies on any number of important healthcare policies and activities and ensure a diversity of opinion and stakeholder input.

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Thank you for the opportunity to provide feedback on the PFS/QPP proposed rule. AAPA welcomes further discussion with CMS regarding our position 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 & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

Jonathan E. Sobel, DMSc, MBA, PA-C, DFAAPA, FAPACVS
President and Chair of the Board