



December 16, 2016

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

**RE: 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**

Dear Administrator Slavitt,

The American Academy of PAs (AAPA), on behalf of the more than 108,500 physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments 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* final rule. AAPA welcomes CMS' expressed interest in continued dialogue with stakeholders such as PAs and other health professionals regarding the Quality Payment Program (QPP). AAPA will continue to offer suggestions for the improvement of the QPP and looks forward to sharing our perspectives, as well as the feedback we receive from practicing PAs, as the program is implemented. After review of CMS' MACRA final rule, AAPA would like to draw your attention to the following comments that will assist CMS in strengthening the QPP.

**The Continued Threat to the QPP Due to a Lack of Transparency**

AAPA is pleased that CMS' MACRA final rule made numerous improvements from the policies stated in the proposed rule. We appreciate that CMS has heard our concerns regarding speed of implementation and administrative burdens, and has finalized policies that permit increased flexibility under the QPP. We particularly approve of CMS codifying the "Pick Your Pace" option for 2017 to allow health professionals more time, should they need it, to ease into the QPP. This addresses AAPA's concerns of the short timeline for health professionals to sufficiently learn about the extensive program and make the corresponding required practice and administrative changes. We also support CMS reducing the MIPS 'Cost' category to zero for 2017, the eased administrative and reporting burdens, and details on the availability of technical assistance for health professionals, especially those in rural communities.

In the final rule, CMS also made great strides toward greater inclusion of health professionals in Advanced APMs by both announcing the intention to reopen/develop more qualified models, as well as by clarifying that health professionals beyond physicians may participate in Physician-focused Payment Models.

However, AAPA remains concerned about certain harmful policies that were not resolved by CMS' final rule. The most prominent of these is the effect of "incident to" and shared visit billing on the QPP, which forces health professionals that are considered Eligible Clinicians (ECs), such as PAs and nurse practitioners (NPs), to be hidden providers, with all or some of their personally provided services billed to and attributed to someone else. By inaccurately attributing services to professionals other than those who rendered the services, biases occur regarding the data collected. In turn, if this data is biased, decisions made utilizing this information, such as the ability to participate in a program (MIPS) or public rankings (scores on Physician Compare) may be inaccurate, incomplete or nonexistent. AAPA believes transparency and appropriate attribution of services are essential qualifications for effective performance improvement, efficient resource allocation and patient choice.

Not having a score or having a score based on limited data might have negative implications beyond the bonus/penalty aspect of MIPS. Patients may make decisions about which healthcare professional they choose based upon a professional's Physician Compare scoring. Employers may decide to utilize composite scores to determine who they will and will not hire.

It is for these all of these reasons AAPA continues to implore CMS to remedy the lack of transparency that billing under a professional who did not render the care creates. We are advocating for a solution that allows for the capture of the rendering provider when services are billed under the physician's name. AAPA can supply suggestions as to how this information may be captured, such as the inclusion of a PA's NPI in the shaded portions of 24 J, and stands ready to discuss this further with CMS. We reiterate that two cornerstones of the QPP are the integrity of reported data and the accuracy of attributed services. We believe finally working to develop a solution to the longstanding problem of hidden medical services created by "incident to" and shared visit billing would support the ideals of transparency, improvement and patient awareness of options, which the QPP seeks to establish.

### **Other Concerns Not Addressed in the Final Rule**

In addition to AAPA's concerns regarding transparency, we would like to reiterate other potential policy improvements that we recommended in response to the proposed rule that merit further consideration. These comments pertain to feedback reports and the reporting/reimbursement gap. We are pleased CMS has indicated openness to considering alterations to both.

First, AAPA wishes to restate our support for more frequent feedback reports (beyond an annual report) provided to health professionals. An annual feedback report does not allow for corrective action. Quarterly reports, meanwhile, would permit professionals to make necessary adjustments to be in

alignment with CMS QPP requirements. This would also support CMS' expression of interest in regular dialogue with health stakeholders regarding the QPP. Further, AAPA continues to support feedback reports being supplied on all four MIPS categories, as opposed to solely Quality and Cost.

Second, AAPA wishes to reaffirm our concerns regarding the two-year delay between reporting and reimbursement. 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. This is especially worrisome if CMS continues to only provide feedback reports annually, and only on two of the four MIPS categories.

### **Improvement Activities – PI CME**

In the final rule, CMS issued the following response to various comments regarding the use of CME as a potential Improvement Activity:

*“Response: We appreciate the suggestions that we grant improvement activities credit for activities already certified as CME activities, however, for the transition year of the MIPS program we do not have sufficient data to identify which CMEs could be included as activities. We will consider these recommendations for additional activities in future years as part of the nomination process.”*

AAPA believes there is great value in CMS approving and utilizing existing practice improvement metrics and programs if those programs meet appropriate, objective standards. A common-sense approach would be to authorize PAs who are already using AAPA Performance Improvement CME (PI-CME) programs to improve practice quality to continue to use those same programs to meet the QPP practice improvement requirements.

AAPA recommends any future addition of CME activities include those tailored to all ECs, including PAs. Specifically, we would like to propose inclusion of completed activities designated as AAPA's Category 1 PI-CME. In review of the current list of Improvement Activities, we are confident AAPA's Category 1 PI-CME is more rigorous than many of the measures currently listed, extending beyond merely completing a module or submitting data, but rather requires action and measurement for improvement.

AAPA's PI-CME is a structured process for evaluating the evidence-base for one's own behavior and making carefully considered adjustments accordingly. The activity has 3 phases:

- Stage A – Compare your current practice in a specific clinical area against recognized, evidence-based standards. Assess your current performance, identify performance gaps and discover opportunities for improvement.
- Stage B – Develop and implement a plan to improve your practice. For example, you might decide to take a class about a specific procedure, develop new patient education material, change the sequence in which you approach routine tasks, or make a simple process change.

- Stage C – Reassess your practice to evaluate the effects of your improvement plan. If you were able to improve, what factors facilitated your success? If you were not able to improve, what barriers did you encounter that prevented a successful outcome? What would you do differently next time?

As AAPA’s Category 1 PI-CME requires participants to analyze clinical records before and after implementing customized improvement plans, its inclusion as one of the MIPS Improvement Activities would aid not only PAs in reporting, but encourage informed and tested care improvement. More information can be found here: <https://www.aapa.org/performance-improvement-cme/>.

AAPA appreciates this opportunity to provide feedback on the MACRA final rule 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 cursive script that reads "Josanne K. Pagel".

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