



**American Academy of
PHYSICIAN ASSISTANTS**

2318 Mill Road, Suite 1300
Alexandria, VA 22314
P 703 836 2272 F 703 684 1924
E aapa@aapa.org
www.aapa.org

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
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7500 Security Blvd.
Baltimore, MD 21244

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On behalf of the more than 76,000 clinically practicing physician assistants represented by the American Academy of Physician Assistants (AAPA), we appreciate having an opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule implementing section 3022 of the Affordable Care Act that provides guidance for the Medicare Shared Savings program and accountable care organizations (ACOs).

AAPA is the only national professional association representing PAs in all medical and surgical specialties. It is estimated that in 2009 nearly 300 million patient visits were made to physician assistants (PAs). Many of those visits were from Medicare and Medicaid beneficiaries.

AAPA and practicing PAs throughout the country support the concept of establishing and promoting health care systems that encompass the goal of delivering better quality, highly coordinated care to patients while also achieving improved cost efficiencies. The PA profession looks to be a full partner with CMS and other stakeholders in assisting in that transformation.

The Medicare Shared Savings program and ACO proposed rule represent a complicated set of rules, guidelines, and concepts, many of which will need to be more fully explained. AAPA is interested in engaging in further discussion with CMS officials on a host of issues surrounding the proposed rule, such as how quality measures will be applied, anti-trust exemptions, and implementation of the risk models being utilized. However, we have a unique concern with the manner in which PAs are integrated into the Shared Savings/ACO program.

AAPA applauds provisions in federal legislation, subsection 1899(h)(1)(B) of the Affordable Care Act (the Act), and in the proposed rule that specifically includes PAs in the definition of ACO professionals. This inclusion of PAs recognizes and underscores the unique value of PAs in the delivery of health care services.

However, we are extremely disappointed with the fact that PAs are not included in the definition of primary care professional. Under the proposed rule, that definition is limited to physicians, as defined at 42 CFR410.20(b)(1), who have a primary specialty designation such as internal medicine, general practice, family practice, or geriatric medicine. The reality is that PAs are one of three health care professional groups who deliver the type of primary care services as proposed in the rule which include Healthcare Common Procedure Coding System (HCPCS) codes 99201- 99215, 99304-99340, 99341-99350, including the Welcome to Medicare Exam (G0402) and the Annual Wellness Visits (G0438 and G0439).

The proposed rules suggest an intent to assign beneficiaries to an ACO only if those beneficiaries received a plurality of their primary care services, based on allowed charges, from physicians meeting the primary care professional definition. The exclusion of PAs from the category of primary care professional means that patients treated autonomously by PAs in a PA-physician team care model will not be included in the calculation to meet the minimum 5,000 beneficiary threshold. We can think of no rational explanation for patients treated by PAs and meeting the primary care services requirement to be excluded in this manner. Such a rule actually provides a disincentive for practices to utilize PAs despite the fact that they have been proven to be high quality, cost-effective health care professionals.

AAPA recognizes that any attempt to transform the health care system from a fragmented, volume-based delivery system to a model that is vested in achieving better outcomes and extending access to care will fail if an adequate supply of qualified health care professionals is not available to deliver that care.

While legislative language found in section 1899(c) technically allows for a methodology that only permits certain physicians to be included as primary care professionals, other options are available under the discretionary authority provided to the Secretary of Health and Human Services. In fact, section 1899(i) allows for the utilization of other payment models under the Shared Savings program. Specifically, section 1899(i) of the Act provides that the Secretary may use either a partial capitation model **or other payment model** (emphasis added), rather than the payment model described in section 1899(d) of the Act, for making payments under the Shared Savings Program. **Note:** the assignment under 1899(c) is also the payment composition for section 1899(d).

From a payment policy viewpoint, section 1899(i) provides the Secretary with the ability to recognize an alternative payment system that could include beneficiaries treated by PAs, if the primary care services requirements are met.

RHCs/FQHCs

The proposed rule points out that due to the cost-based, all-inclusive methodology of billing that occurs in RHCs and FQHCs, the exact service (as designated by a Current Procedural Terminology code) being provided is not evident on the claim form submitted to the intermediary. While this is true and would be an impediment to determining if a particular service met the requirement of being a primary care service, CMS should allow for the ability of the RHC/FQHC to alter and/or augment its billing processes and begin to collect such information if the practice desired to be more fully included in the ACO program. Clearly, the ability to “look back” over a period of years would likely not be an option in these practices. However, the importance of including health care practices that so obviously serve an underserved population group should be given a great deal of consideration.

The financial incentives contained in the ACO proposed rule that encourage ACOs to include RHCs and FQHCs are recognized and appreciated. However, the opportunity for full inclusion of RHCs and FQHCs in ACOs and allowing patients being treated in these practice settings to be counted toward the 5,000 beneficiary minimum are essential components in ensuring the viability of practices that consistently treat an exceedingly vulnerable patient population group.

The Shared Savings and ACO proposed regulations seek to outline the structural and implementation requirements of a health care concept that many expect to dramatically impact how health care is delivered and financed in this country. While attempting to achieve the dual goals of improving care quality and reducing costs, it should be noted that for most health care professionals and organizations the ACO model is principally conceptual in nature with numerous questions and concerns yet to be answered. For that reason ACO regulations must have maximum flexibility in their design in order to appropriately meet the unique and individual needs of patient population groups and differing practice settings.

PAs are an essential part of any health care delivery model utilized in this country. We urge CMS to strongly consider the need to more fully integrate PAs into the ACO regulations, specifically by including patients treated by PAs toward the 5,000 minimum beneficiary threshold, in order to ensure the success of health care transformation which starts with a commitment to timely access to needed health services for patients.

AAPA looks forward to a continued dialogue on these important issues. If you have any questions concerning our comments please contact Michael L. Powe, AAPA's Vice President of Reimbursement and Professional Advocacy, at michael@aapa.org or 571-319-4345.

Sincerely,

A handwritten signature in black ink that reads "Patrick Killeen". The signature is written in a cursive style with a large initial "P".

Patrick E. Killeen MS, PA-C
President