LEADERSHIP AND ADVOCACY SUMMIT

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We're all EARs: Effective Advocates for Reimbursement

Michael Powe, Vice President, Reimbursement & Professional Advocacy

Sondra M. DePalma, DHSc, PA-C, DFAAPA, Senior Director, Regulatory and Professional Practice

Trevor Simon, MPP, Director, Regulatory Policy

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Comments as Advocacy

Trevor Simon, MPP

Director, Regulatory Policy

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It’s been a while – What’s new? (A sample)

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- **Four New State Medicaid Programs Enroll PAs as Rendering Providers**
- **More Commercial Payers Now Enroll PAs**
- **Completed Medicaid Survey to Identify Advocacy Issues**
- Direct Pay Finalized in the 2022 PFS
- New Advocacy Resources

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PA Win – Medicaid Enrollment

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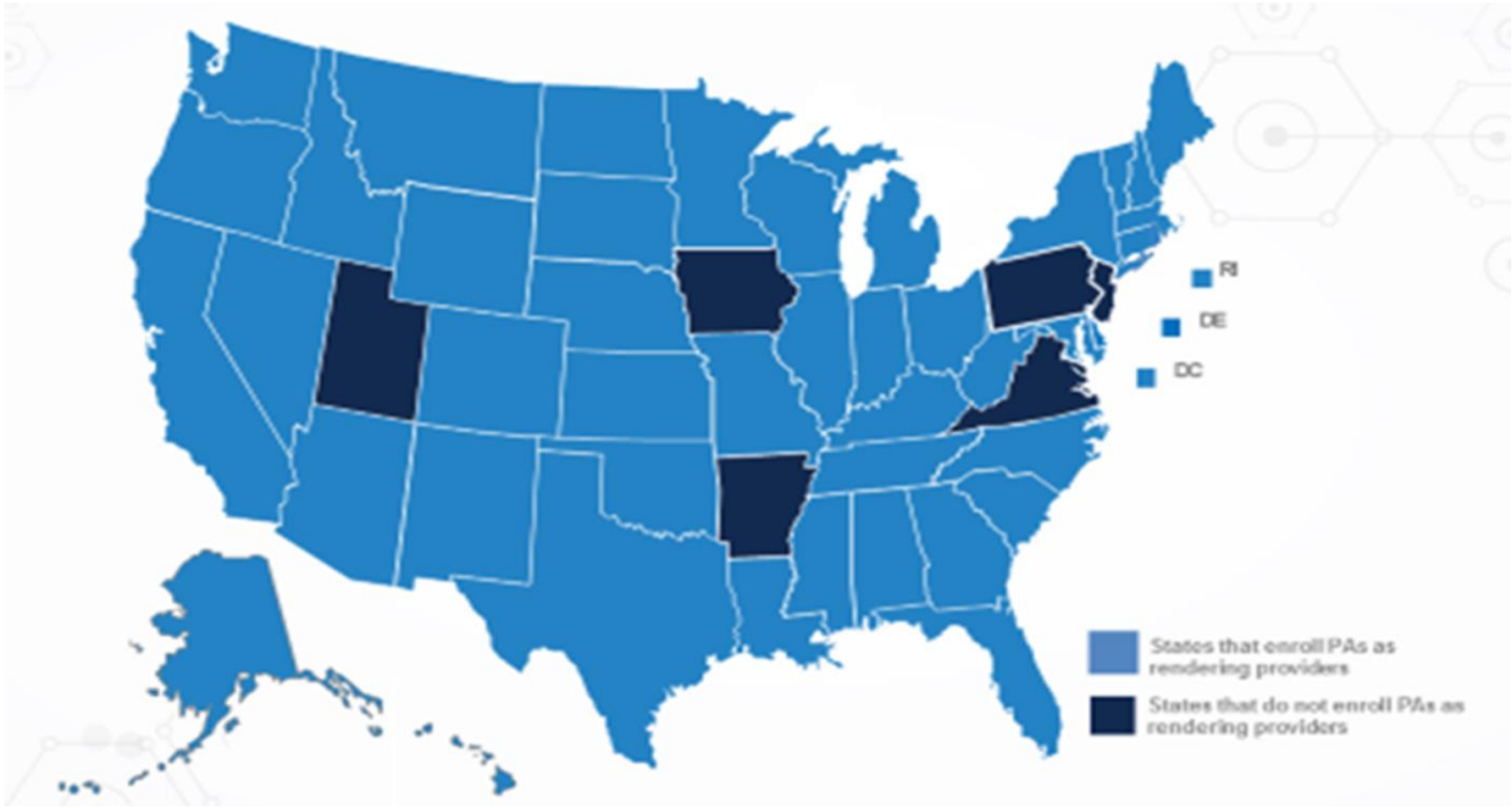
Our Understanding of the Landscape in Early 2021

44 states and DC enrolled PAs



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PA Win – Medicaid Enrollment

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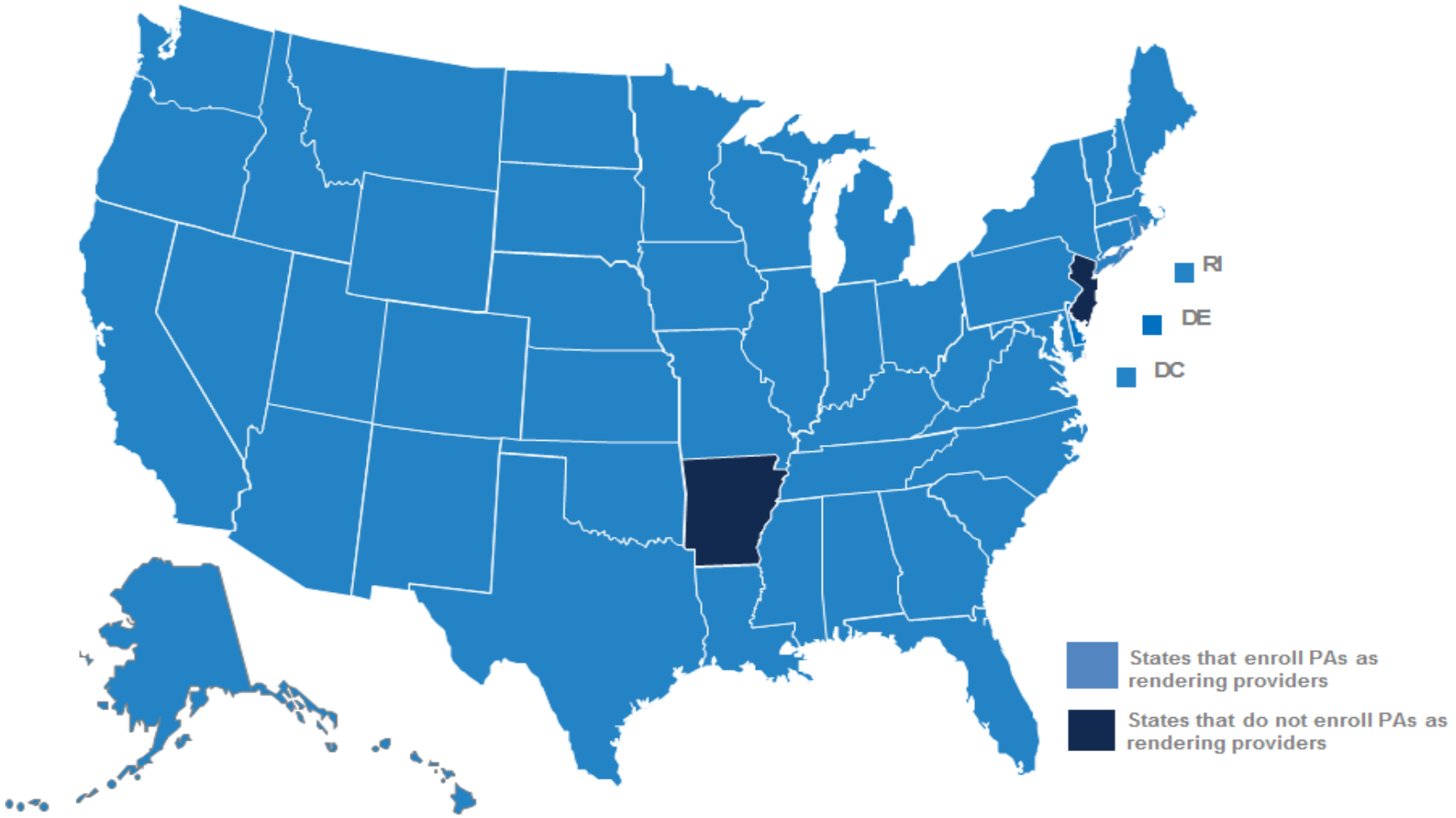
The Landscape Today

48 states and DC now enroll PAs



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PA Win – Commercial Payer Enrollment

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- Recall: AAPA surveyed the top seven commercial payers (4 with national policies, 3 with state-by-state policies)
- Solicited information on several issues, one of which was enrollment
- Two of the payers (both with state policies) identified two states that did not yet enroll PAs in commercial plans
  - Anthem CA, Anthem NV
  - Highmark PA, Highmark DE

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PA Win – Commercial Payer Enrollment

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- AAPA has since confirmed policy changes (enrollment of PAs) in all four remaining state payers:

☑ Anthem CA	☑ Highmark PA
☑ Anthem NV	☑ Highmark DE

- For each of the seven payers, we have received confirmation of PA enrollment in writing (by manual, bulletins, or email)

- Caution: This does not mean that the major payers enroll PAs in all their plans (for example, a Medicaid managed care plan or behavioral health plan)

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PA Win – Medicaid Survey

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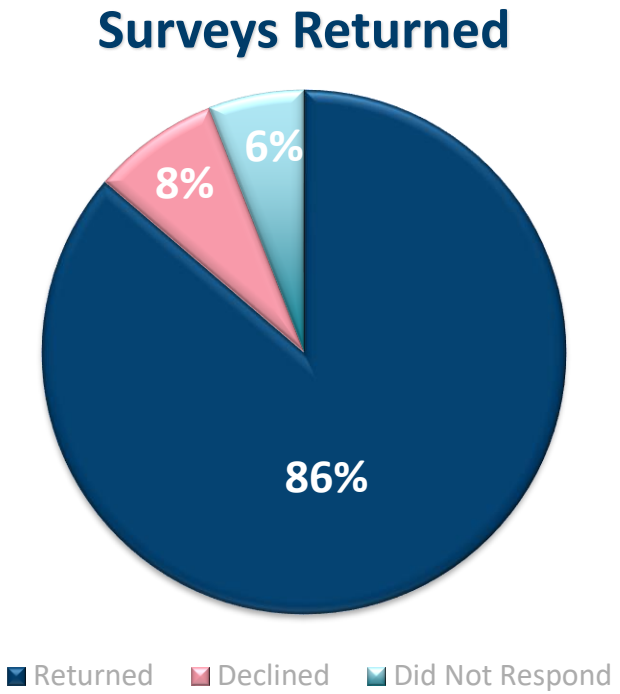
- AAPA recently sent surveys to all 50 states and DC
  - AAPA sends such surveys to payers regularly (last in 2018)
  - 14 topic areas

- Received back 44/51
- 4 declined
- 3 did not respond



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PA Win – Medicaid Survey Themes

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No clear pattern on which restrictions are most common

Not all potential prohibitions communicated to AAPA are sourced to written text

There's general interest by agencies in providing accurate information that we can pass along to PAs

Allows AAPA to identify opportunities for advocacy efforts going forward

There may be a greater number of Medicaid agencies that enroll PAs as billing providers than previously thought

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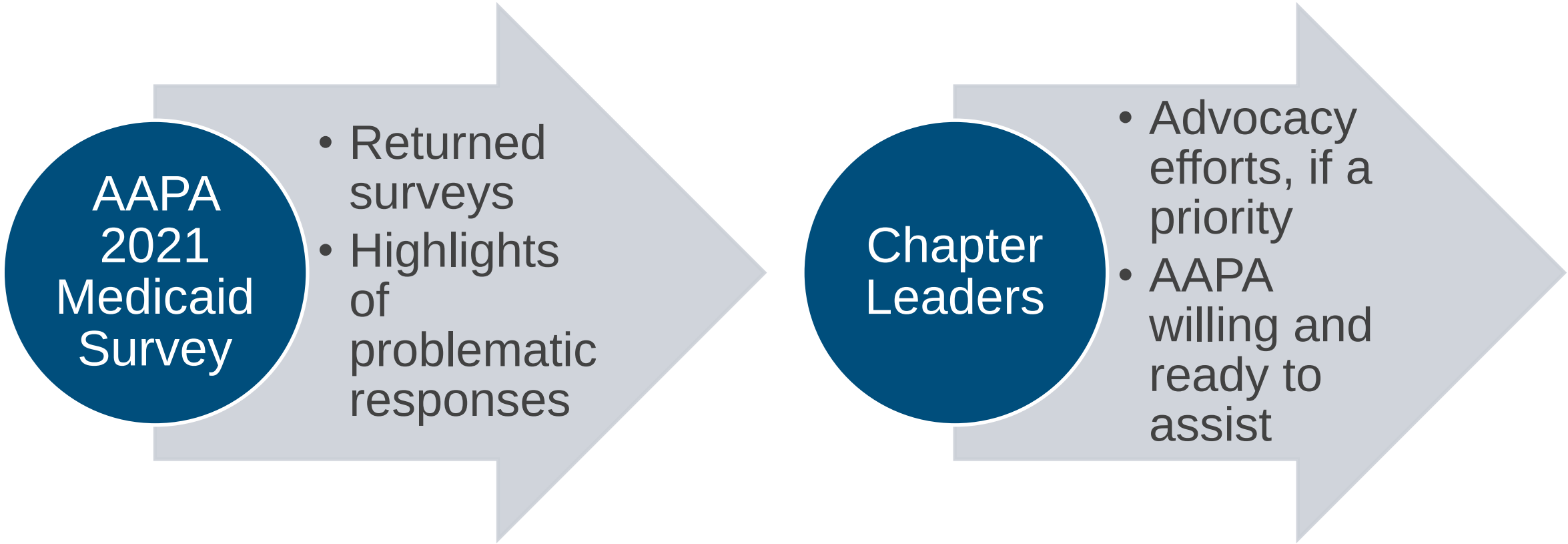
PA Win – Medicaid Survey



AAPA Regular Advocacy Actions

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Policy wins don't just happen… they require diverse advocacy actions

Comment Letters	**Meetings with Stakeholders and Policy Makers**	**Coalition Participation**	**Educational and Advocacy Resource Development**	**Gathering Policy Information Directly From Sources**

We're going to spotlight one of these advocacy actions today

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Comment Opportunities – What are they?

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What	Documents requesting feedback from the public on potential policy changes
Who	Typically, federal agencies
When	Some are recurring, others are one-offs. Usually open for comment for 2 months (may be shorter)
Why	Agencies claim to read all comments and take responses into account when finalizing proposed policies/developing future policies

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Comment Opportunities – What are they?

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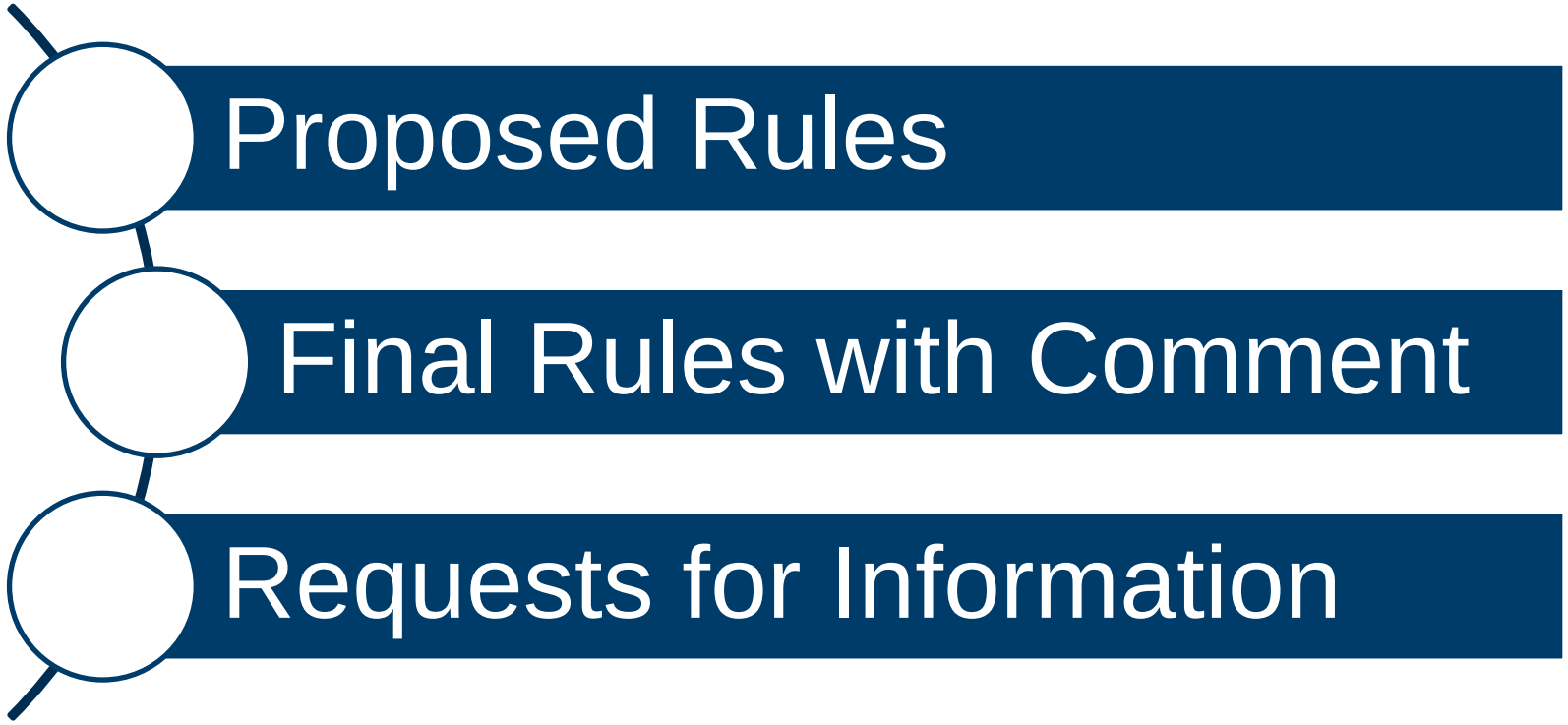
The types of documents AAPA provides comment on



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AAPA Comments In 2022 (so far)

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- 2023 Hospital Outpatient Prospective Payment System Proposed Rule
- 2023 Physician Fee Schedule Proposed Rule
- Medicare Advantage Request for Information
- Rural Emergency Hospitals Proposed Rule
- U.S. Department of Education Student Assistance Proposed Rule
- HHS Initiative to Strengthen Primary Health Care Request for Information
- 2023 Medicare Prescription Drug Benefit Programs
- Addressing Disparities and Promoting Equity in Healthcare

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Comments

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- AAPA utilizes every opportunity to identify unnecessary or outdated obstacles to PAs providing care
- Some comments are targeted on one issue, others contain multiple subjects
- The annual Physician Fee Schedule is the largest vehicle for policy changes used by CMS

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Examples of Subjects Discussed…

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Transparency and “incident to”
Split (or shared) visit billing
Hospice restrictions
Therapeutic shoes
Telehealth
Inpatient Rehabilitation Facilities
Medical Nutrition Therapy
Colonoscopies
EKGs
SNFs and NFs
Payer policy alignment
Cardiac/Intensive Cardiac/Pulmonary Rehab
Global surgical packages
Evaluation and Management guidelines

Behavioral/Mental Health
Diagnostic tests
Ambulance services
Initial vs. subsequent visit claim submission
ACO attribution
Mobile distribution of care
Conversion factors
Levels and method of supervision
MIPS thresholds for participation
Medicare’s Physician Compare website
CME
Digital quality measurement
Qualifications for APM participation
MIPS Value Pathways

Punchline: This was all from just one comment letter!

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Comment Themes

AAPA frames our comments in broadly-acceptable themes

Increasing Patient Access

- Example: Promoting enrollment of PAs to be able to provide behavioral/mental services

Reducing Burden

- Example: Eliminating burdensome requirements for patient transfers

Maximizing Care Efficiency

- Example: Removing SNF or IRF physician-participation requirements

Promoting Transparency

- Example: Solving problems created by “incident to”

Removing Antiquated Policies

- Example: Eliminating hospice restrictions and other Medicare barriers

Inclusion of Comparable Health Professionals

- Example: Identifying PAs and NPs in regulations for Rural Emergency Hospitals and CMMI models

Policy Consistency

- Example: Standardization of Medicare policy between Fee-for-service and Medicare Advantage

Addressing Disparities of Care

- Example: Promoting autonomy of health professionals in underserved areas

Want to learn  ?

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AAPA's Comment Webpage: https://www.aapa.org/advocacy-central/federal-advocacy/communications-with-federal-executive-branch/#tabs-4-cms

CMS Rulemaking: https://www.cms.gov/regulations-and-guidance/regulations-and-policies/cms-rulemaking

Regulations.gov: https://www.regulations.gov/

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Split (or Shared) Billing

Sondra M. DePalma, DHSc, PA-C, DFAAPA

Senior Director, Regulatory and Professional Practice

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Split (or Shared) Services

Services performed in combination by a physician and a PA (or NP) in a hospital or facility setting

Optional Medicare Billing Policy

https://www.cms.gov/files/document/r11288CP.pdf#page=9

Split (or Shared) Billing

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Services Eligible for Split (or Shared) Billing

- Hospital inpatient (initial and subsequent encounters)
- Hospital outpatient services, including observation care and emergency department services
- Critical care services (as of 1/1/2022)
- Certain SNF/NF services (as of 1/1/2022)

Does **NOT** apply to procedures

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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Split (or Shared) Billing

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Billing Requirements

- Hospital inpatient (initial and subsequent encounters)
- Physician and PA/NP must work for **same group**
- Physician and PA/NP must treat patient on **same calendar day**
- Either physician or PA/NP must have **face-to-face encounter** with patient
- Physician must provide a **"substantive portion"** of encounter
- -FS modifier must be included on claim to identify service as split (or shared)

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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Split (or Shared) Billing

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Substantive Portion

Before 2022	2022	2023	2024 ????
All or some of the history, exam, or MDM	History, exam, or MDM in its entirety -OR- More than half of total time	MDM in its entirety -OR- More than half of total time	More than half of total time

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Split (or Shared) Billing

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What to do About Changes to “Substantive” Definition

- Determine what percentage (if any) of your service is affected
  - May have limited affect on surgical service lines or with non-Medicare populations
- Look at overall cost/benefit when/if changing workflows
- May need to adjust incentives/bonuses

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Split (or Shared) Billing

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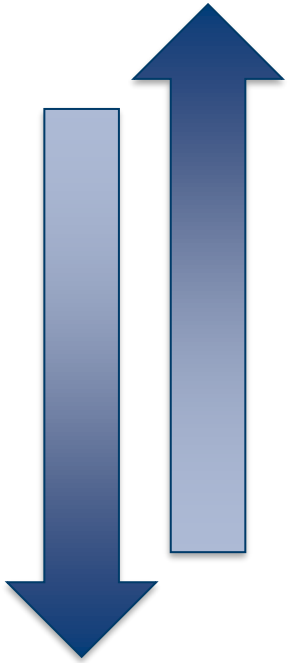
More Desirable

Greater Benefits



Less Desirable

Least Benefits

- Autonomous patient panels
- No change in workflow, but services billed under PA
- Hybrid change in workflow - some services billed autonomously and others as split (or shared)
- Change in workflow to continue to bill all (or most) services as split (or shared)
- Removal of PAs from workflows

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Split (or Shared) Billing

- Autonomous patient panels
- No change in workflow but services billed under PA
- Hybrid change in workflow - some services billed autonomously and others as split (or shared)
- Change in workflow to continue to bill all (or most) services as split (or shared)
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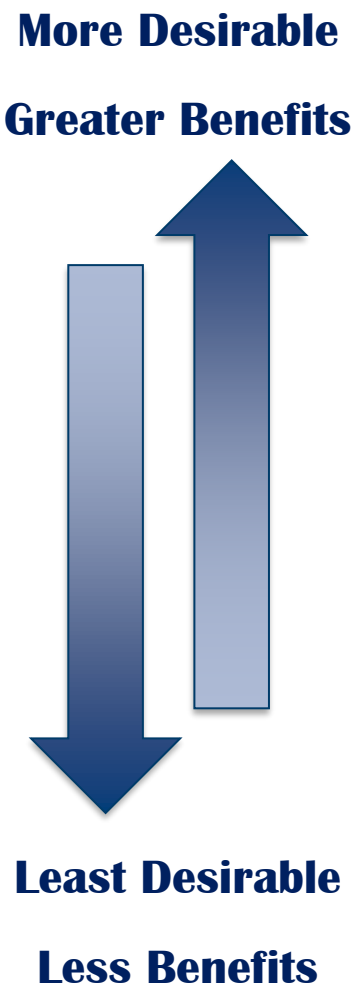


↑ Efficiency

↑ Contribution Margin and Downstream Revenue

↑ Satisfaction

↓ Contribution Margin

↓ Efficiency

↓ Satisfaction

Delays in Care

↓ Pt Throughput/Bed Turnover

↑ Burnout

Fraud & Abuse Risk

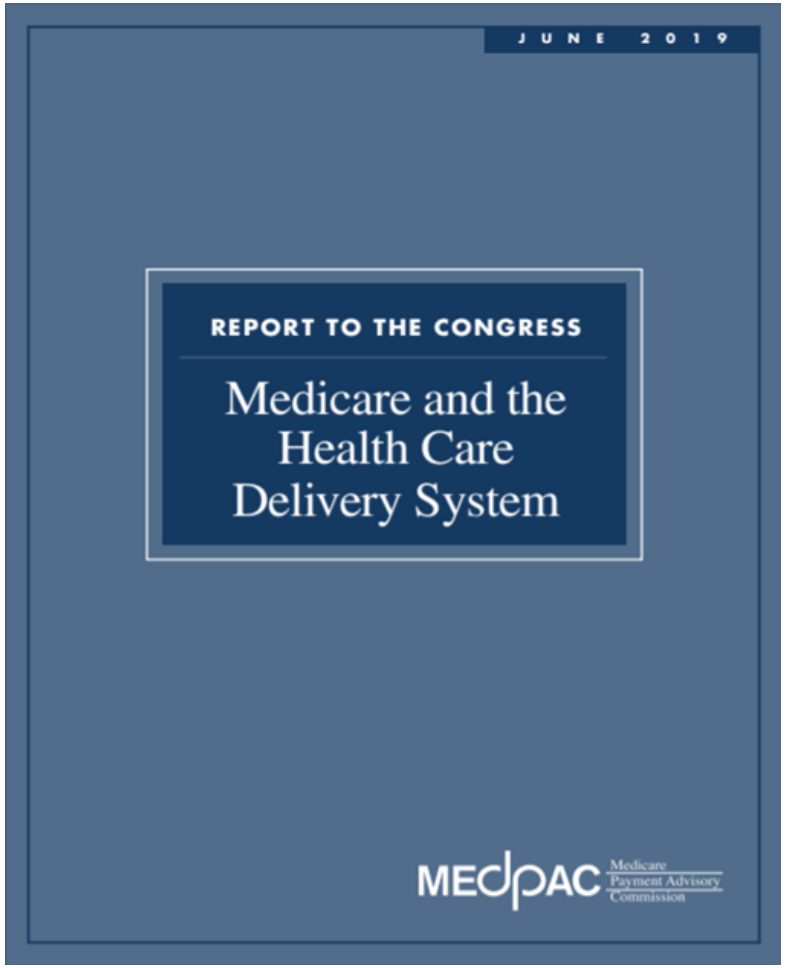
↑ Administrative Burden

Mercy Medical Center Agreed to Pay $210,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims that Misidentified Rendering Providers

Office of Inspector General

After it self-disclosed conduct to OIG, Mercy Medical Center (MMC), Ohio, agreed to pay $210,739.53 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that MMC billed for the professional services of physician assistants under the supervising physician's provider number as a shared/split, when the **documentation did not meet the requirements for a shared/split visit**.


What about the extra 15%?
More than made up for by increased efficiency, decreased burden, and overall contribution margin.



"PAs nearly always lower costs and increase profits for their employers because their salaries are less than half of physician salaries, on average, but their services can be billed at the full physician rate or at a modest discount ."

http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

Reimbursement & Profit

PA Reimbursement = 85% of Physician Fee Schedule

PA Salary = 30-50% of Physician Salary

Contribution margin for a PA/NP is no less than (and sometimes greater than) that of a physician

Contribution Margin

revenue after costs

Personnel Costs

Salary	PA < physician
Benefits (PTO, CME allotment, etc.)	PA ≤ physician
Recruitment/Onboarding	PA ≤ physician
Malpractice Premiums	PA < physician
Overhead (building, staff, supplies)	PA = physician

Overall cost to employ PA ↓↓↓ physician

Cost Effectiveness of PAs & NPs

A hypothetical day In the hospital	Physician	PA
Revenue with physician and PA providing the same 99232 service	$1080 ($72 X 15 visits)	$915 ($61 X 15 visits) [85% of $72 = $61]
Wages per day	$960 ($120/hour x 8 hours)	$440 ($55/hour x 8 hours)
"Contribution margin" (revenue minus wages)	**$120**	**$475**

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Cost Effectiveness Take-Aways

- Point is not that PAs produce greater revenue than physicians
- Point is that PAs generate a substantial contribution margin for a practice/employer even when reimbursed at 85%
- An appropriate assessment of monetary “value” includes revenue, expenses, and non-revenue-generating services

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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“Value” is More than Revenue

Definition of “Value”

- The worth of something
- Relative importance, usefulness, or desirability of something or someone

> “Nowadays people know the price of everything and the value of nothing.”
>
> Oscar Wilde

The Value of PAs

- Increase reimbursement and revenue
- Improve access to care and patient throughput
- Provide expanded hours and services
- Facilitate care coordination and communications
- Contribute to process/quality improvement and outcomes
- Improve patient and staff satisfaction

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AAPA Payer Summit

Michael Powe, Vice President

Reimbursement & Professional Advocacy

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Payer Summit

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- AAPA's Reimbursement Team has always interacted with commercial payers (phone calls, surveys, email exchanges, casework, meetings).
- Unlike Medicare, commercial payer policies are not necessarily revealed or discussed publicly before being implemented.
- Often, health professionals are left to react to payer reimbursement and coverage policies with limited to no input.

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Payer Summit

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- In a rapidly changing health care system and with constant improvements to PA practice acts, the concern is that payer understanding of PAs is not current/accurate.

- Potential negative decisions involving scope, authorizations, referrals, primary care provider status, etc. could occur due to incomplete or misinformation.

- Can lead to potential limits to PA utilization and employment.

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Secondary issue: payers are becoming owners of clinics; employers of health professionals

- United Health Group owns Optum OptumCare (one of the top 10 largest health care systems in the United States).
- CVS buys Signify Health to establish another foothold into primary care (in addition to Minute Clinics).
- Humana to purchase senior-focused primary care entity which is expected to open 67 clinics by early 2023 (previous deal made to spend up to $1.2 billion to open about 100 new value-based primary care clinics for Medicare patients).

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Goal

- Develop long-term relationship with payers that will facilitate an ongoing, mutual exchange of information.
- Identify a specific point of contact at payers.
- Increase AAPA/PA input in payer decision making processes.

How

- Convene a gathering of commercial payer representatives (some of whom administer Medicare Advantage plans) and engage in a series of educational sessions regarding PAs/PA practice.
- Periodic follow up to maintain communication.

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Payer Summit

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What Payers Need to Know

- PA education (didactic hours, clinical rotations (hours and exposure to various specialties)
- Scope of practice, care quality equal to physicians, high patient satisfaction
- Physician relationship/physician collaboration
- PA role in value-based care
- Increasing access/ensuring network adequacy
- Improving access to mental health care services
- Impact on work force (physician shortage)
- Discover concerns/”pain points” for payers – transparency, specialty identification

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Creation of Payer Educational Brochure

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- Reimbursement Team is developing an electronic informational brochure to help educate payers.
- Infographic with text providing objective data, research and facts about PA practice.
- Will be made available to PAs and constituent organizations for their use with local payers.

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Behavioral Health Outreach

Trevor Simon, MPP

Director, Regulatory Policy

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Addressing Behavioral Health Restrictions

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- While Medicare policy is permissive of PAs ordering and providing behavioral/mental health services, many commercial payers, and Medicaid programs, have restrictive policies pertaining to PAs and behavioral/mental health.

- While only approximately 2,262 PAs practice in psychiatry, this number has remained low due to excessive restrictions placed on PAs in this specialty by some commercial payers

- The removal of certain policy restrictions put in place by commercial payers could allow more PAs to practice in behavioral health and lessen the effects of behavioral/mental health shortages

- AAPA is beginning an outreach effort to commercial payers, first surveying payers, and then meeting with those that do not have PA-friendly policies
  - Potential payers surveyed include large commercial payers that also cover behavioral/mental health services, as well as those that are exclusively known for behavioral/mental health

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Behavioral Health Outreach

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Develop advocacy resources regarding PAs in behavioral health

Survey behavioral health payers regarding current policy

Identify policies prohibitive of PAs

Meet with behavioral health payers to advocate for necessary policy changes

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Behavioral Health Resources

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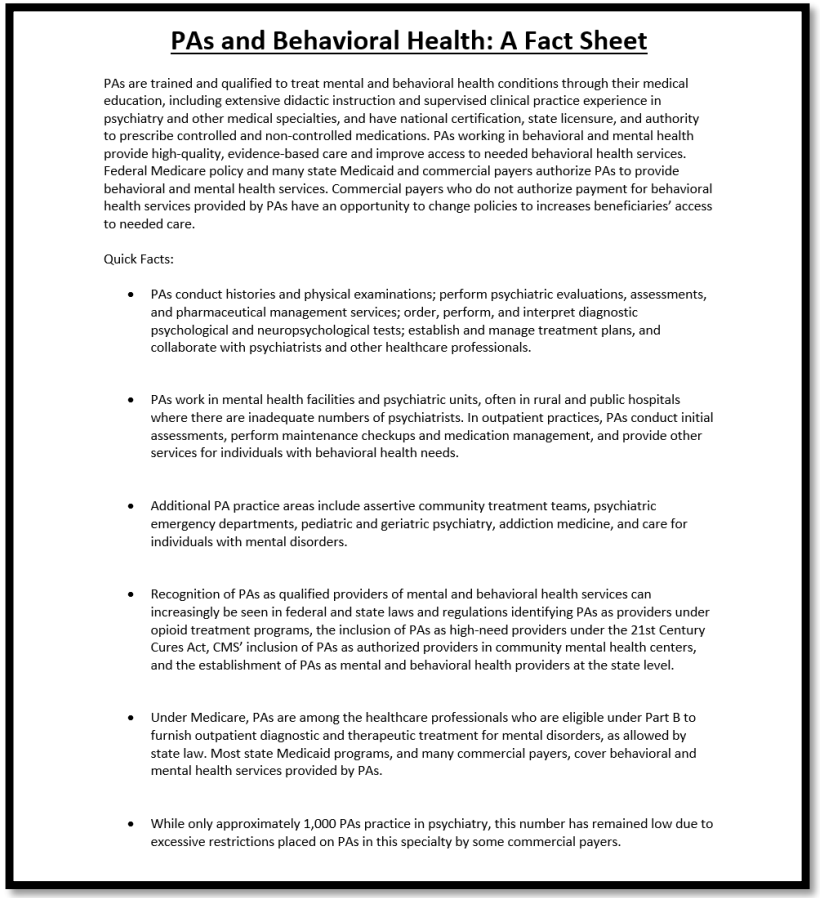


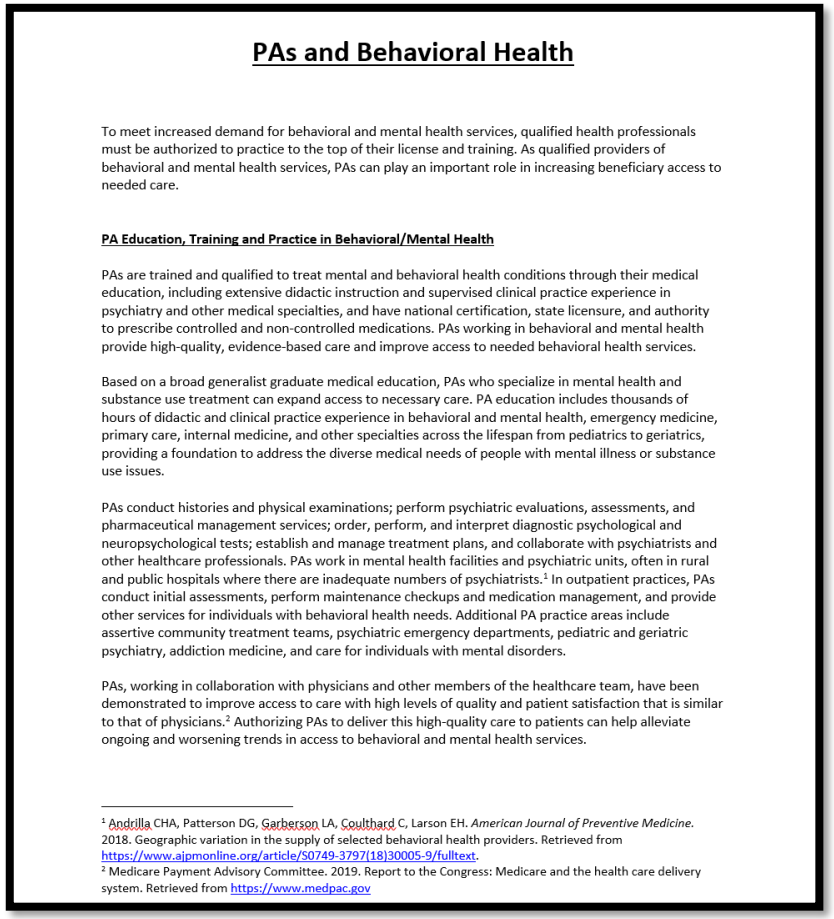
PAs and Behavioral Health: A Fact Sheet

PAs are trained and qualified to treat mental and behavioral health conditions through their medical education, including extensive didactic instruction and supervised clinical practice experience in psychiatry and other medical specialties, and have national certification, state licensure, and authority to prescribe controlled and non-controlled medications. PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral health services. Federal Medicare policy and many state Medicaid and commercial payers authorize PAs to provide behavioral and mental health services. Commercial payers who do not authorize payment for behavioral health services provided by PAs have an opportunity to change policies to increases beneficiaries' access to needed care.

Quick Facts:

- PAs conduct histories and physical examinations; perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans, and collaborate with psychiatrists and other healthcare professionals.
- PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists. In outpatient practices, PAs conduct initial assessments, perform maintenance checkups and medication management, and provide other services for individuals with behavioral health needs.
- Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.
- Recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act, CMS' inclusion of PAs as authorized providers in community mental health centers, and the establishment of PAs as mental and behavioral health providers at the state level.
- Under Medicare, PAs are among the healthcare professionals who are eligible under Part B to furnish outpatient diagnostic and therapeutic treatment for mental disorders, as allowed by state law. Most state Medicaid programs, and many commercial payers, cover behavioral and mental health services provided by PAs.
- While only approximately 1,000 PAs practice in psychiatry, this number has remained low due to excessive restrictions placed on PAs in this specialty by some commercial payers.

A 1-Page Fact Sheet



PAs and Behavioral Health

To meet increased demand for behavioral and mental health services, qualified health professionals must be authorized to practice to the top of their license and training. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

PA Education, Training and Practice in Behavioral/Mental Health

PAs are trained and qualified to treat mental and behavioral health conditions through their medical education, including extensive didactic instruction and supervised clinical practice experience in psychiatry and other medical specialties, and have national certification, state licensure, and authority to prescribe controlled and non-controlled medications. PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral health services.

Based on a broad generalist graduate medical education, PAs who specialize in mental health and substance use treatment can expand access to necessary care. PA education includes thousands of hours of didactic and clinical practice experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan from pediatrics to geriatrics, providing a foundation to address the diverse medical needs of people with mental illness or substance use issues.

PAs conduct histories and physical examinations; perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans, and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists.[1] In outpatient practices, PAs conduct initial assessments, perform maintenance checkups and medication management, and provide other services for individuals with behavioral health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs, working in collaboration with physicians and other members of the healthcare team, have been demonstrated to improve access to care with high levels of quality and patient satisfaction that is similar to that of physicians.[2] Authorizing PAs to deliver this high-quality care to patients can help alleviate ongoing and worsening trends in access to behavioral and mental health services.

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[1] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. *American Journal of Preventive Medicine.* 2018. Geographic variation in the supply of selected behavioral health providers. Retrieved from https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext.

[2] Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from https://www.medpac.gov

A 3-Page Primer

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Behavioral Health Survey

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- Traditionally more difficult to solicit returns from behavioral health payers
- Surveyed seven payers (will survey nine)
- While only one response so far, many possible reasons for this
  - Historical uncommunicativeness, incorrect contacts, suspicion of requests for information
- Considering alternatives such as approaching associations in which they are a part, reaching out for an initial meeting first, finding more reliable contacts

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Discussion

Identification of PAs by Specialty

Michael Powe, Vice President

Reimbursement & Professional Advocacy

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Discussion Issue – Identifying PAs by Specialty

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Value of not identifying PAs by specialty

- Maintain existing flexibility for PAs to move between specialties, professional satisfaction
- PAs meeting changing work force needs by shifting to areas of need

Value of specialty identification

- PAs listed in provider directories by specialty (as opposed to a PA category)
- PCP status with more payers
- Assist PA coverage in traditionally challenging specialties (e.g., psychiatry/ behavioral health)

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PA Identification by Specialty

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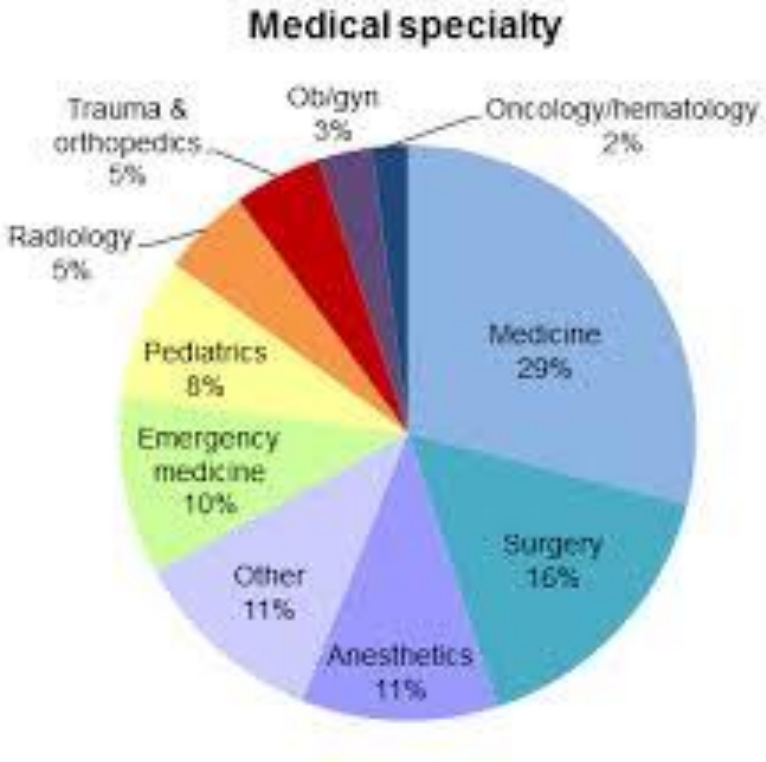
Law of Unintended Consequences/Potential Downside

How would identification within a specialty occur?

- Self-attestation?
- Certifying exam/additional educational requirements?
- Additional specialty-specific CME, residency programs?
- Some other “proof of competency” required by payers?



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Discussion

“Incident to” – Time for a Policy Change?

Michael Powe, Vice President

Reimbursement & Professional Advocacy

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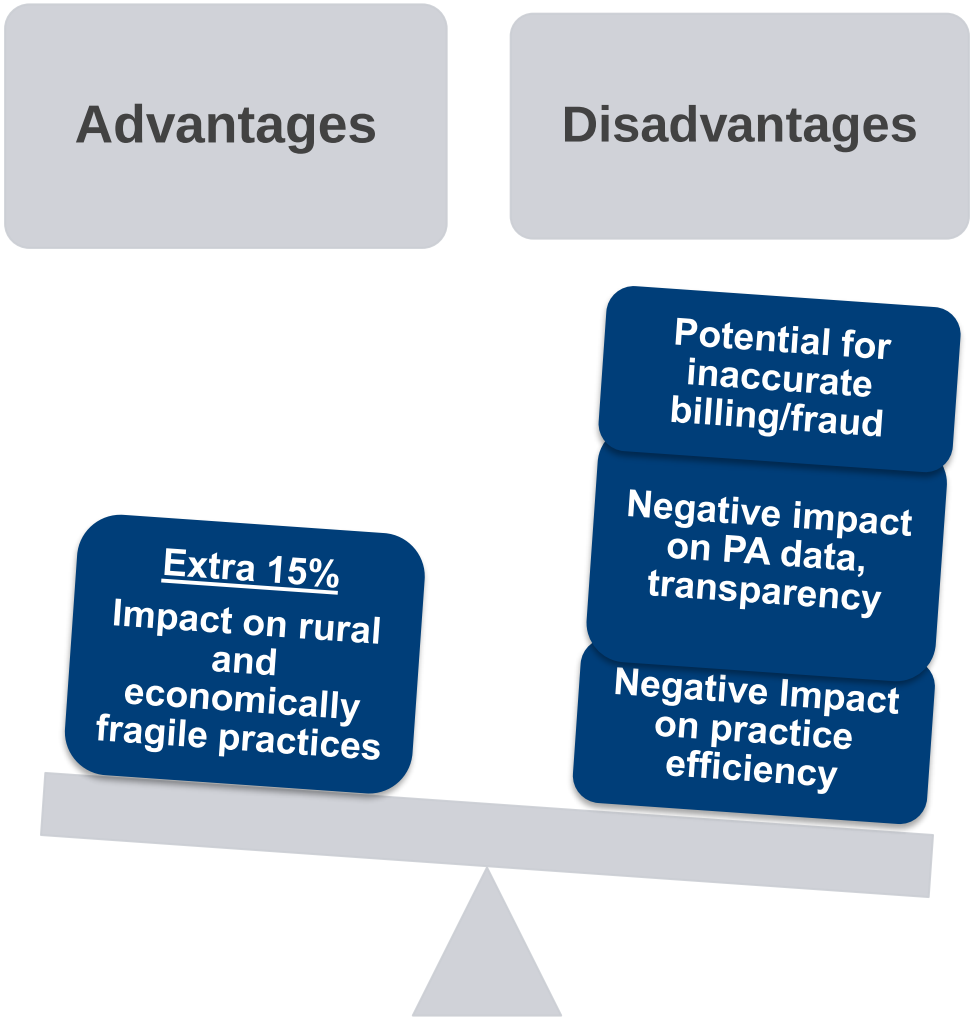
Is Billing "Incident to" Worth it?



Discussion Issue – Incident to Billing Keep or Eliminate?

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- AAPA is on record stating that “incident to” should be eliminated.
- Trade-offs should occur with some of the financial savings being used as an offset for other PA Medicare regulatory coverage changes (hospice, diabetic shoes, medical nutritional therapy, etc.).
- Consideration of raising the Medicare PA/NP reimbursement rate should be in the mix.

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Take Advantage of AAPA Resources

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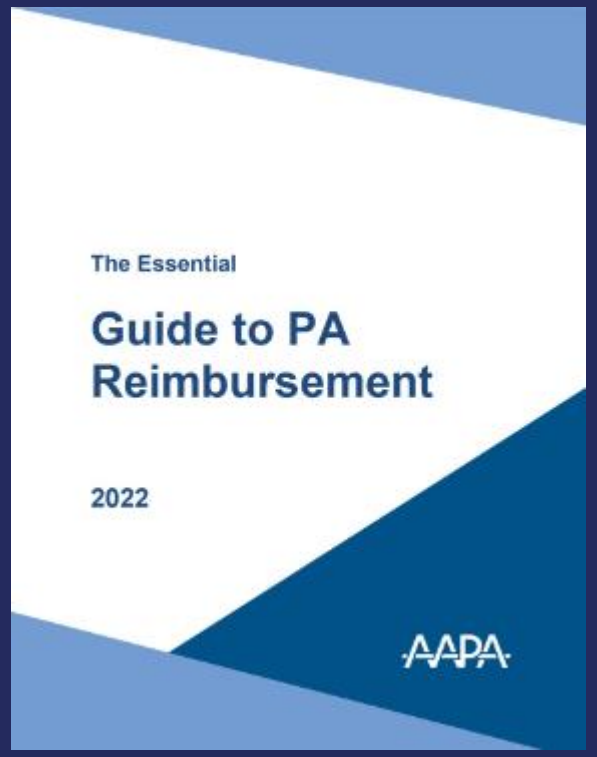
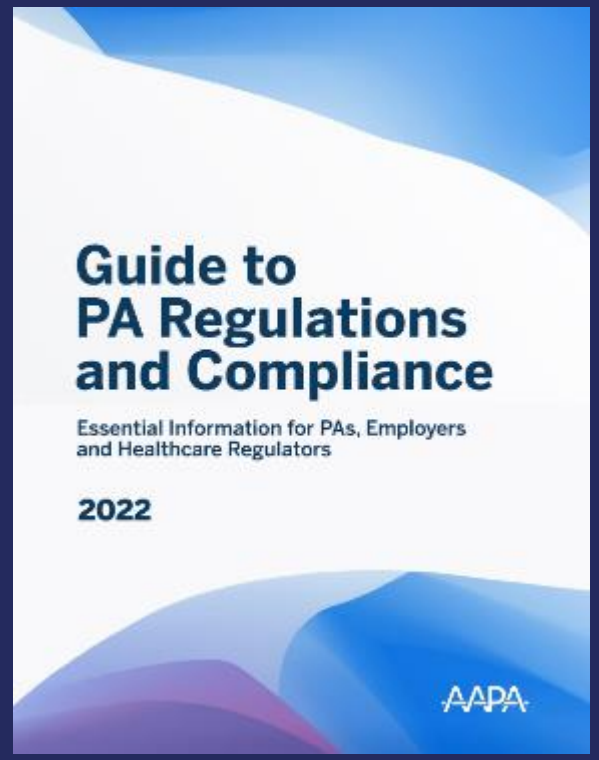


FREE to AAPA Members

https://www.aapa.org/advocacy-central/reimbursement



LEADERSHIP AND ADVOCACY SUMMIT

https://www.aapa.org/advocacy-central/reimbursement/

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Reimbursement

AAPA works with all public and commercial third-party payers to ensure coverage for the medical and surgical services delivered by PAs. A thorough understanding of PA payment policies is essential for demonstrating PA value, maximizing the collection of appropriate reimbursement and avoiding concerns about fraud and abuse.

Also see the **Summary of PA Reimbursement** and a **Primer on PA Reimbursement**.

Special Reimbursement Alerts:

CMS is asking that PAs help spread the word at upcoming back-to-school medical visits about the necessary steps for renewal of Medicaid and CHIP coverage. You can find more information here: **Renew Your Medicaid and CHIP Coverage.**

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Other Resources

- CME on-demand in Learning Central
- Live Events
  - Executive Leadership Conference
  - National Conference
- Student Presentations – Available for PA students and PA programs to meet ARC-PA curriculum requirements (standards B2.14 and B2.17)
  - PA Students: Navigating PA Reimbursement
  - PA Students: PA Practice Considerations
  - PA Students: Demonstrating PA Value

Questions?

Email: reimbursementteam@aapa.org