Medicare Part B Direct Payment for PAs

Action Requested: Cosponsor S. 596 / H.R. 1052, the Physician Assistant Direct Payment Act. This legislation would authorize PAs to receive direct reimbursement from Medicare Part B.

Currently, PAs deliver a wide range of medical and surgical services to Medicare beneficiaries, but are unable to receive direct payment from Medicare Part B. Outdated language requires that Medicare reimbursement for PA services can only be paid to a PA's employer. PA-provided services, which are performed in all specialties and practice settings, are covered by virtually every public (Medicare, Medicaid and Tricare) and commercial third-party payer.

Background: PAs are the only health professionals who are assigned National Provider Identifier (NPI) numbers and are authorized to bill Medicare for their services yet are not able to receive direct payment for those services. For PAs, Medicare payment is currently required to be paid to an employer. The inability to be directly paid often leads to complex administrative arrangements and increased burdens for hospitals, medical groups and healthcare organizations utilizing PAs when the facility does not have a traditional employer/employee relationship with medical providers at the facility (such as when providers are independent contractors or work for a staffing company).

Medicare directly pays other health professionals (e.g. physicians, advanced practice nurses, physical therapists, psychologists, podiatrists, social workers, and others) that bill the program under their own name and provider number.

PAs that want to work in a retail clinic or a certified rural health clinic, join a medical group that contracts with a hospital or open a primary care clinic in an underserved community are adversely affected by the inability to receive direct payment. Authorizing Medicare direct payment for PAs will level the playing field so PAs can compete with other health professionals on the basis of their clinical competence without the concern of administrative burdens hindering employment opportunities and payment.

Direct payment provides the flexibility necessary to meet the clinical needs of patients in a variety of practice settings and care models. Traditional practice models of one physician employing one PA have been replaced by models in which PAs, physicians and other healthcare team members are employed and utilized by hospitals, health systems, and emerging healthcare delivery venues in more innovative, patient-centered arrangements. Medicare must recognize and promote these new practice models that have the ability to improve the timely delivery of care to patients, reduce costs and increase quality.

Even with direct payment, many PAs will reassign their payment to a medical group, hospital, or healthcare system, in a manner similar to that of physicians and nurse practitioners. Employment relationships and the hierarchy of clinical authority and responsibility in clinics, hospitals and other practice settings will not change based on the ability of PAs to receive direct payment.

AAPA Legislative Recommendation: Authorizing PAs to receive direct payment moves Medicare forward in its transformation towards more innovative, value-based care and practice models. Medicare policies need to be modernized to maximize PA effectiveness in delivering superior value and outcomes for patients.

AAPA urges Congress to support and pass the Physician Assistant Direct Payment Act (S. 596 / H.R. 1052) introduced by Senators John Barrasso (R-WY) and Tom Carper (D-DE), and Representatives Terri Sewell (D-AL) and Adrian Smith (R-NE) to authorize PAs to receive direct payment from Medicare Part B in the same manner currently allowed for other healthcare professionals such as nurse practitioners and physicians.

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Examples of How Lack of Medicare Direct Payment Impacts PA Practice:

1) A PA in rural Redfield, Iowa has owned a certified rural health clinic (RHC) for years. RHCs are paid on a cost-based, per encounter methodology. Medicare requires that all RHCs offer an array of diagnostic tests to all patients who need those services. However, the RHC program has over the years excluded certain services from the RHC bundled payment. Diagnostic tests are among those excluded services. Because PAs are unable to receive direct payment from Medicare, PAs in RHCs who offer these required diagnostic services are not able to be paid. Essentially, the Medicare program is requiring that a medical service be provided but is not providing a way to pay for the service. The PA who owns the RHC, Ed Friedmann, PA-C, says that "I want to provide the full range of care to my patients. However, it seems incredibly unfair that the Medicare program does not offer a way to pay for the service. I'm forced to lose money each time one of these diagnostic tests is provided to a patient. Authorizing PAs to receive direct payment would eliminate this problem."

2) A hospital wants to contract with a private hospital medicine group of physicians, PAs and NPs to provide 24-7 coverage for the hospital. The hospital wants to pay the private hospital management group for its work with the group's providers reassigning Medicare reimbursement to the hospital. Physicians and NPs can participate in this arrangement. PAs, who do not receive direct payment and, therefore, can't reassign their Medicare reimbursement to the hospital, can't participate in the arrangement.

3) A surgeon in private practice often wants a PA to work with him/her to deliver first assist services in the operating room. The surgeon may not have enough volume of surgical cases to hire a PA full-time so the PA works with the surgeon part-time. A PA may choose to work with three or four different surgeons in this manner as a contractor. Not being able to receive direct payment from Medicare creates numerous administrative hurdles and time delays for PAs to be paid for their first assisting duties.

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