**Statement for the Record**
**Submitted to**
**U.S. House Committee on Energy and Commerce**
**Subcommittee on Health**
**On Behalf of the American Academy of PAs**

On behalf of more than 115,000 nationally-certified PAs (physician assistants), the American Academy of PAs (AAPA) welcomes the opportunity to submit a statement for the record regarding the hearing held by the U.S. House Committee on Energy and Commerce Subcommittee on Health on "MACRA and Alternative Payment Models: Developing Options for Value-based Care."

AAPA would like to thank Chairman Burgess and Ranking Member Green for holding this important hearing, and for continuing to focus on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015, along with the issue of how providers are compensated by the Medicare program for the care that they provide. AAPA would also like to thank the witnesses for their testimony.

AAPA enthusiastically supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015, and has worked with Congressional and agency stakeholders to develop the replacements for the Sustainable Growth Rate (SGR) payment model.

PAs are responsible for providing care for hundreds of millions of patient visits each year. PAs are an essential part of the healthcare delivery system, and it is important to ensure that PAs are able to fully participate and be recognized in the Quality Payment Program. AAPA is happy to continue working with members of this committee and CMS to ensure reasonable measures are taken to ensure that Medicare and patients have the data that is necessary to evaluate health care rendered by all Medicare providers, including PAs. .

**Data Accuracy and Accountability**

AAPA would like to take this opportunity to express our concern about the accuracy of the data that will be used as part of the Quality Payment Program (QPP), since so much of the agency's QPP efforts are dependent on the collection and analysis of accurate and actionable data dealing with quality, outcomes, resource allocation, and other factors.

Unfortunately, the care provided by PAs is often attributed to physicians. This means that any payment system that seeks to assess value and outcomes, and reimburse accordingly, is likely to be fundamentally flawed. Quite simply, PAs may not be able to fully participate in the QPP program if the services they deliver to Medicare beneficiaries are often not properly attributed to them.

In the transition to Advanced Alternative Payment Models (Advanced APMs), as well as the Merit-based Incentive Payment System (MIPS), it will be essential to ensure that the reporting of information and metrics for the QPP is accurate. The Medicare program has a billing and reimbursement policy that has the effect of concealing the identity of certain healthcare professionals, including PAs, who deliver direct care to the patient. The Medicare program allows services provided by PAs in a private office or clinic to be billed under the name and National Provider Identifier (NPI) of the collaborating physician using a billing mechanism known as "incident to." When services delivered by PAs are billed under the name of the PA's collaborating physician as an

"incident to" service, the PA's name and NPI typically do not appear on the claim form. This means that the actual provider of care, in this case the PA, is not identified in the CMS claims system and QPP data sources are populated with information that does not identify the actual provider of care. PAs report that as much as 40-60 percent of the services they deliver in the private office setting are billed "incident to" the physician.

While PAs are considered eligible clinicians (ECs) in the QPP, this does not guarantee program participation. To maintain eligibility, PAs, physicians and other health professionals must exceed a "low volume threshold," which means having more than $90,000 in Medicare billing charges or providing care for more than 200 unique Medicare Part B enrolled beneficiaries in a calendar year. Although PAs may actually treat a sufficient volume of eligible patients, they may not be recorded in the CMS claims system as having treated the requisite number of patients or billed for the appropriate amount because a substantial number of their patient visits are billed under a physician's name using "incident to" billing - thereby falling below the eligibility threshold. As long as a portion of the services delivered by PAs are "hidden", the threshold will be a problem and the work performed by the PA will be inappropriately assigned to a physician who did not personally perform the service.

The premise of QPP and other health-related programs is that evidence-based, quality-driven information should guide clinical practice and be used to evaluate performance, and it is essential that the data underlying these programs accurately reflect the care being provided by each health professional. CMS must ensure appropriate provider attribution and eliminate the problem of "hidden" providers. The first step is to require the name and NPI number of the rendering provider (i.e., PA) on all "incident to" claims.

For purposes of accountability and in keeping with the goals of the QPP, AAPA recommends requiring claims submitted using the "incident to" billing provision to specifically include the name and NPI number of the PA who actually provided the care. This process would not change the fact that the claim is billed under the collaborating physician or the payment amount, nor would it change the fact that payment is made to the PA's employer. It would simply improve the accuracy of the data and allow an honest assessment of which health professionals meet the patient volume and dollar threshold criteria of the QPP.

**ACO Assignment**

Accountable Care Organizations (ACOs) are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. While PAs are listed by Medicare as one of three types of health professionals who deliver primary care services, only patients who have had at least one visit by a physician are eligible to be assigned/attributed to an ACO. Medicare beneficiaries treated solely by PAs and Nurse Practitioners (NPs) cannot be assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA (or NP) is the only health professional in the community. As a result, the physician requirement prevents Medicare fee-for-service beneficiaries in these communities from accessing the coordinated care provided by ACOs.

Because of these concerns, AAPA strongly endorses H.R. 1160, the ACO Assignment Improvement Act of 2017. This bipartisan legislation, introduced by Representatives Derek Kilmer (D-WA) and Lynn Jenkins (R-KS), will allow Medicare beneficiaries who receive their primary care from PAs to be assigned to Medicare Shared Savings Program (MSSP) ACOs without arbitrarily requiring the patient to see a physician. Allowing primary care services furnished by PAs and other advanced care providers to count for purposes of ACO assignment will remove a barrier for care, and will also encourage ACO formation by helping healthcare providers attain enough ACO beneficiaries to participate in the MSSP. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages.

AAPA is committed to working with Congress and CMS on APMs and how healthcare providers are compensated by Medicare, and looks forward to a continued working relationship with Congress to ensure the best possible care for all Medicare beneficiaries. Thank you for the opportunity to submit a statement, and please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at 571-319-4338 or theuer@aapa.org with any questions.