American Academy of PAs

Advancing Data Transparency: Understanding the Impact of PAs

"Transparency" in health care is the practice of making available to the public and other stakeholders information on the health care system's quality, efficiency, availability of health professionals and pricing, and the consumer's experience with care. The timely use of accurate, actionable health care data has the ability to positively influence the behavior of patients, providers, payers, and others to achieve improved care outcomes.

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Nearly all medical services delivered by PAs are reimbursed by public and commercial payers. However, a substantial percentage of medical services delivered by PAs to Medicare, Medicaid, and commercial payer beneficiaries are currently "hidden" in the health care system. This is due to certain payer billing provisions and/or the fact that some payers do not enroll/credential PAs, bundled or global payment methodologies, and other factors that make it difficult, if not impossible, to appropriately measure the volume of services and the quality of care delivered by PAs. When PA-provided services are not transparent, the impact of PAs within public and commercial health care programs is lost.

Additional transparency concerns exist due to payer choices that are separate from reimbursement policies. These choices include whether and how PAs are represented in provider directories, as well as the extent to which policies pertaining to PA practice and coverage are clearly detailed and understood in publicly available documents, such as manuals, transmittals, bulletins, newsletters and more.

This paper will identify some of the major obstacles to transparency of PAs and PA services and why these obstacles persist. Subsequently, we will explore a number of negative consequences of the lack of appropriate identification of PAs. Finally, we will provide potential solutions to ameliorate or remedy the detrimental effects brought about by the transparency obstacles identified.

Obstacles to Transparency

PAs are highly trained health care professionals who practice in all medical settings and specialties with a high level of autonomy. They diagnose and treat illness, prescribe medications, order and interpret tests and provide patient education. However, certain payer provisions and policies have led to misattribution of services provided by PAs and are harmful to the effective and efficient delivery of care. The rapid increase in the use of data in health care decision making, the negative effects of inaccurate attribution in data, as well as incomplete information provided to consumers, have further accentuated the problem with outdated policies that prevent the recognition of PAs. Below are some of these archaic policies that are obstacles to transparency. Many of these transparency concerns similarly apply to Advanced Practice Registered Nurses.

"Incident to"

"Incident to" is a Medicare billing rule that, when certain conditions are met, allows medical services performed by one health professional, such as the PA, in the office or clinic to be submitted to the Medicare program and reimbursed under the name of a physician. Reimbursement for an "incident to" claim is paid at 100 percent of the physician fee schedule as opposed to 85 percent reimbursement when the same service is billed under the name and NPI number of a PA.

Due to the way services billed "incident to" are reported through Medicare's claims process as having been delivered by a physician, it is nearly impossible to accurately identify the type, volume, or quality of medical services delivered by PAs. This lack of transparency has a negative effect on patients, the development of health policy, the Medicare program and PAs.

States that Do Not Enroll PAs as Rendering Providers Under Medicaid

Medicaid programs allow PAs to treat Medicaid patients in all 50 states and the District of Columbia, and PAs are expected to enroll as, at minimum, "ordering and referring providers." Enrollment as an ordering and referring provider means that a payer requires that a PA's name and NPI be included with any orders and referrals made. However, forty-four states and the District of Columbia voluntarily enroll PAs as a different provider type: rendering providers. Enrollment as a rendering provider means that, in most instances, the name and NPI are to be included on a claim to identify the PA as the health professional who provided a service. This is in contrast to the claim attributing the service to the physician and effectively hiding the PA. The goal of this status is transparency and being able to properly identify who actually provided the care. In the remaining six states, PAs are enrolled as "ordering and referring providers" and their services are instead attributed to the collaborating physician.

Commercial Payer Policies that Require Billing Under the Physician

Some commercial payers do not officially list PAs as eligible health professionals, often known as enrolling and/or credentialing. While services provided by PAs are still reimbursed by such payers, the expectation is to attribute all services to the collaborating physician, as opposed to including a PA's name and NPI on a claim form to indicate they rendered the service. This policy of enrollment/credentialing may vary within a company, dependent on whether the line of business is commercial, Medicaid managed care, Medicare Advantage, or behavioral health. As payers increasingly use data to make decisions on network adequacy and provider value, payers who do not separately identify PAs within their systems will have inaccurate information with which to perform these analyses.

Lack of Recognition of Services Provided by PAs Employed by Hospitals

Some hospitals may have contractual arrangements with insurance companies that specify that the professional services provided by PAs are not separately reimbursed, but rather included in an increased facility fee paid to the hospital. When this occurs, there is no guarantee the increased amount paid to the

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hospital under the facility fee is equivalent to the number and types of services provided by PAs. In addition, if PAs are not permitted to separately submit claims for the services they provide, then important data on those services cannot be captured and used for analysis and decision-making. It should be noted that including professional services delivered by PAs in the facility fee is generally considered inappropriate for Medicare's purposes. While hospitals would encounter compliance issues for this manner of billing under Medicare, commercial payers and Medicaid programs are not necessarily required to follow Medicare rules for their non-Medicare beneficiaries.

PA contribution can similarly be "lost" when services are part of a global surgical package. Because reimbursement for many surgical procedures is bundled into a single payment for pre-, intra-, and postoperative care, PAs providing pre- and post-operative services may have productivity misattributed to the physician. Reimbursement for a PA first assisting is separately payable and not part of the global surgical payment package.

EHR Design

Electronic health records (EHRs) can be designed and customized to meet the needs of those health professionals who use them. However, not all purchasers of EHRs have optimized system designs to ensure transparency and accuracy of information regarding who provides care. If an EHR does not have functionality to allow work performed by more than one provider during the same patient encounter to be documented and retained, it may be impossible to verify the amount of work performed by each professional in instances such as shared visit billing. Similarly, it may be impossible to identify the actual service provider in instances such as "incident to" billing when a claim is submitted under a physician's name and NPI and is not traceable to a PA.

Restrictive Provider Directories

Provider directories are listings maintained by public and commercial payers that alert beneficiaries to the health care professionals within their insurance network. The information in a provider directory varies from payer to payer, but may include information regarding provider specialty, location, contact information, certification, languages spoken, and whether they are accepting new patients, among other information.

While not always the case, PAs are occasionally omitted from a payer's provider directory, or are not appropriately listed by the specialty in which they practice in the same manner as physicians or nurse practitioners. Instead, payers may list PAs under the category of "physician assistant" making them unable or difficult to be found by patients who typically look for a health professional based on practice specialty. Many states have laws and rules requiring health plans to maintain accurate and comprehensive provider directories. However, these laws and policies vary widely and may contain general or vague language relating to the types of providers that must be listed. Other states may have laws or policies with ambiguous language requiring the inclusion of "all providers." Most concerning is that some state laws contain physician-centric language that could be interpreted as enabling payers to exclude health care professionals, such as PAs.

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The Absence of or Ambiguous Language Regarding PA Policies in Official Payer Reference Documents

The need for transparency regarding PAs extends beyond the identification of services provided and encompasses the need to clearly mention PAs in official reference documents. Frequently, manuals, handbooks, newsletters, and bulletins are silent or ambiguous on reimbursement and claim submission requirements for PAs. This lack of information frequently leads to confusion, varying interpretations and disruptions in billing.

The Consequences of Insufficient Transparency Regarding PAs

Consequences of the transparency obstacles listed above are numerous and negatively affect various stakeholders, including patients, payers, employers, and PAs. An exploration of these consequences can be found below.

The Effect on Patients and Care Quality

Patients benefit from increased transparency. In a clinical sense, accurate attribution of services to health professionals who cared for the patient allows health professionals who subsequently deliver care to properly coordinate and communicate with the health professional that actually provided previous care to the patient.

Patients also have an interest in transparent information for the purpose of enhancing their own health care decision making. While not always the case, PAs are occasionally omitted from a payer's provider directory or are included in a manner in which they are unlikely to be found through a beneficiary's search. It is vital that beneficiaries receive complete information about their available network of providers so they can determine the best coverage and care options for them. Information on care availability is particularly important in rural or underserved communities, and for plans with limited networks. Some directories, such as Medicare's Physician Compare, seek to, in addition to listing available health professionals, provide some information on each professional's quality of care. However, when services performed by PAs are hidden, not only is a payer unable to accurately determine PA quality scores because assessments aren't being made using a complete picture of the services PAs provide, but these scores may not appear at all if health professionals have all their services attributed to someone else. PAs not being identified, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a health care provider.

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One of the key issues in ensuring that health care is consumer centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB) notice after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of the visit. The practice of attributing services provided by a PA to a different health professional on claims often leads to patient confusion because the name of the health professional who provided their care does not appear on the resulting MSN/EOB notice. Instead, the MSN/EOB lists the service as having been performed by a physician who the patient may not have seen, which can cause patients to question who their actual care provider is and whether they need to correct what appears to be erroneous information regarding their visit.

The Effect on Data

With a substantial number of services provided by PAs attributed to physicians, publicly available claims data may provide inaccurate information and limit the ability to analyze individual provider contribution or productivity. This may unintentionally lead to imprecise or erroneous data analysis conclusions despite the use of otherwise sound research evaluation methodologies.

The Effect on Payers

When services provided by a PA are attributed to a physician, claims data collected and used by a payer are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of the payer from making the most accurate policy decisions or conducting an appropriate analysis of provider workforce utilization, provider network adequacy, and quality of care. Any analysis using inaccurate data may lead to an inefficient allocation of resources.

The Effect on PA Employers

In a time when performance evaluation and productivity assessments are increasingly dependent on determinations of care quality and provider contribution, employers have an interest in knowing the value, quality, and quantity of care their health professionals provide. While a health professional's productivity is by no means measured only by the reimbursement they generate, if the full range of medical and surgical services is not appropriately tracked, then it is virtually impossible to determine a PA's true level of productivity or contribution to the practice. Unfortunately, PA employers are constrained by the policies of payers with whom they contract, as well as potentially by the EHR system they use, which may not be designed to capture the full contribution of all health professionals.

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While employers operate under the constraints of commercial payer policies and how EHRs collect data, employers can partially remedy misinterpretations of PA contribution by acknowledging current limitations and taking a more wholistic view of PA contributions by looking more broadly at the value PAs provide. Measures of gross billing, net revenue, patient volume, and relative value units (RVUs) may not account for a PA's full contribution. Considering factors such as contribution to practice efficiency, patient satisfaction, and quality and outcome measures may better assess a PA's value to a practice.

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The Effect on PAs

When services provided by PAs are attributed to the physicians with whom they work, it masks the impact of PAs on the health care system. The absence of data attributed to PAs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program, and threatens their ability to be listed along with other health professionals on performance measure websites, such as Physician Compare.

The inability of PAs to be appropriately identified on claims also harms a PA's ability to demonstrate his or her contribution to an employer. While claims reimbursement is by no means the only measure of a health professional's value and productivity, it is an essential component. The inability to demonstrate economic and clinical value, both within the health care system and to an employer, will influence the analysis of PA contributions to the health care organization.

Provider directories that do not include PAs or do not include them in a manner that is searchable in the same way as physicians, decreases the visibility of PAs and fails to identify them as a care option to patients. Finally, a lack of adequate information in payer manuals, bulletins and newsletters may lead to misunderstandings and miscommunications regarding the limitations of PA practice and may disrupt the efficient processing of reimbursement for services provided by PAs.

Challenges to Increased Transparency

Some may misunderstand and believe that making changes to better identify and track PAs for the services they provide will lead to duplicative claims. That is not the case. In fact, PAs are already reimbursed for their services. However, some of those services are being attributed to the physician with whom they work.

Current reimbursement methodologies, such as Medicare's "incident to" billing provision or a commercial payer's policy to bill services delivered by PAs under the physician, can hinder attempts at achieving transparency. If a payer reimburses a PA-provided service billed under the physician at 100 percent, but discounts that same service when billed under the PA's name to 85 percent, group practices, hospitals and other PA employers are incentivized to bill services under the physician to maximize revenue. It is imperative for payers to eliminate this artificial payment incentive if transparency is a serious goal.

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Another challenge to increased transparency may be logistical and financial hurdles. For example, a change in an EHR system may be required to accurately collect data on all health professionals that treat a patient and to report each encounter in an appropriate manner. To remedy this would require employers to work with their EHR vendor and potentially incur additional costs. Similar technological obstacles may exist for payers to adjust the credentialing and claims systems through which they capture and report information.

A final technological hurdle may be the extent to which provider directories need to be programmed and updated to identify PAs appropriately and the necessary work required of the payer to solicit information from PAs on their self-identified specialty.

Recommendations

Irrespective of past reasons for the lack of appropriate PA identification and tracking, the time has come to mitigate the detrimental consequences of this lack of transparency on patients, health professionals, employers and the health system. Below are several recommendations to improve transparency of services provided by PAs.

- CMS should eliminate "incident to" billing as it relates to PAs and APRNs.
- Until "incident to" billing is eliminated, CMS should require the name and NPI of the health professional who rendered patient care be listed and trackable in the Medicare claims system.
- Medicaid programs in the six states that have yet to permit a PA to include their name and NPI on claim forms as having rendered a service should modify their policies to capture this information.
- All commercial payers should enroll/credential PAs and require the identification on a claim of the provider who rendered the service.
- In hospitals, PAs should be reimbursed for professional medical services they deliver and not be included in the facility fee.
- EHRs must be able, and certified EHR technology should be required, to identify which health professional provided what services or portions of services.
- States should have laws requiring that health plans maintain current and comprehensive provider directories, explicitly mandating the inclusion of PAs. PAs in provider directories should also be searchable by provider name, practice location and specialty, like physicians. PAs should be eligible to self-select the specialty in which they practice for designation in provider directories.
- Policies pertaining to PAs should be specifically included in accessible online manuals, handbooks, bulletins, and newsletters. PA scope of practice should defer to PA state law. In addition, manuals should note appropriate reimbursement policies for PAs, such as the claims submission process and reimbursement rate.

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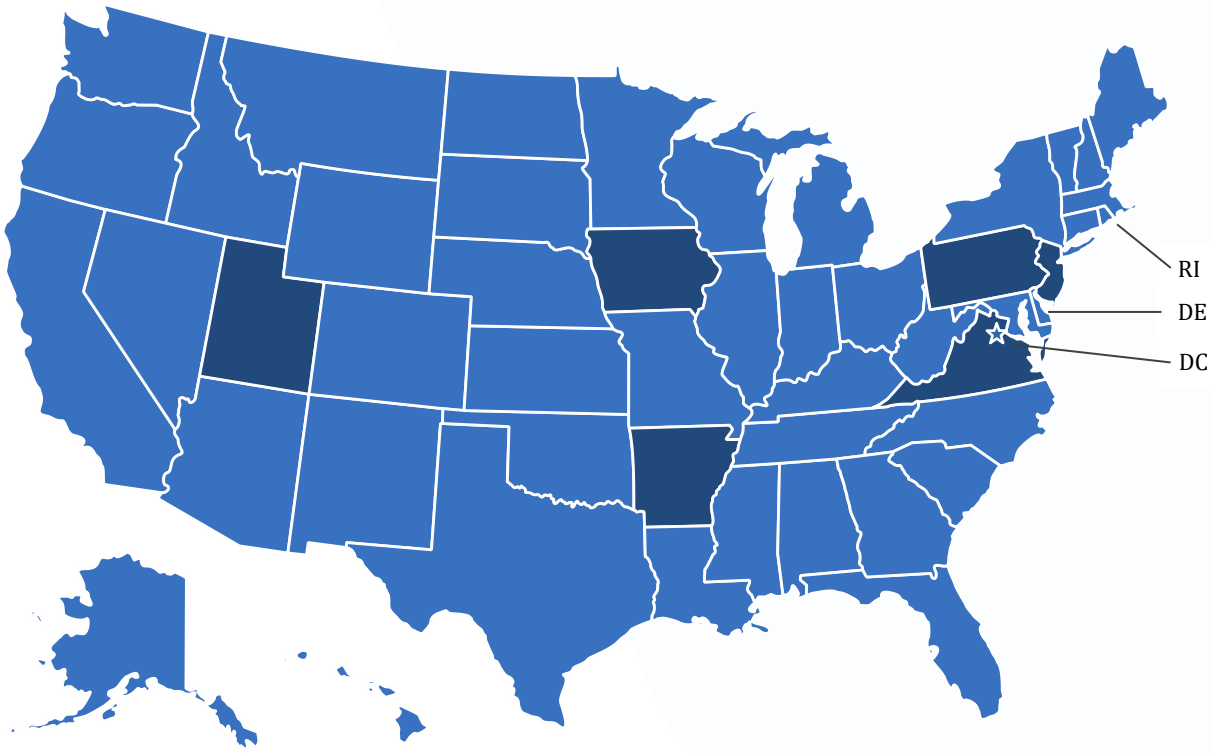
Conclusion

The identification of professional work is important for clinical quality assessment, practice improvement, productivity measurement, care contribution, and population health management. Accurate recognition of PAs will not change state or federal laws regarding the range of services PAs are authorized to perform and will not increase the amount of reimbursement paid. For improved accuracy and accountability, AAPA advocates for claims to be submitted under the name of the health care professional who performed the service.

States that Enroll PAs in the Medicaid Program



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