



Modernizing the Medicare Reimbursement of Medical Care Provided by PAs to Improve Healthcare Care Access, Quality, and Transparency

Background

Current Law

PAs are one of three healthcare professions (along with physicians and nurse practitioners) who provide primary care. In medically underserved areas, PAs often serve as a patient's principal healthcare provider. As master's level graduates of intensive medical education programs, PAs can be found in virtually every medical and surgical specialty. PAs perform physical examinations, diagnose and treat illnesses, care for their own patient panels, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling and make rounds in hospitals and nursing homes. All 50 states and the District of Columbia allow PAs to prescribe medications. PAs believe patient-centered coordinated care produces the best outcomes for patients. PAs are committed to team practice with physicians and other health professionals.

A relic of a bygone era, Medicare reimbursement for medical services provided by PAs is restricted to the PA's employer. (Reimbursement may also be made to a PA-owned, federally certified rural health clinic. See SSA § 1842(b)(6)(C)). This payment restriction to the PA's employer limits the efficient provision of care, restricts the business arrangements in which PAs practice, creates barriers to care in medically underserved communities in which PAs own medical practices, and prevents transparent tracking of the volume and quality of medical and surgical services provided by PAs through Medicare. Improving PA reimbursement will not change the current reimbursement schedule, but it will align the recipient of the reimbursement with the actual healthcare provider to the benefit of the broader healthcare system.

Improvements for a Modernized Medicare Payment System

1. Modernize reimbursement practices to reimburse PAs directly for patient care in the same manner as all other Medicare providers.
2. Permit PAs, like other primary care providers reimbursed under Medicare, to order and provide hospice and home healthcare for their patients.

History of PA Medicare Reimbursement

Medicare coverage of physician services provided by PAs was first authorized in 1977 through the Rural Health Clinic Act. The PA profession was very young at the time -- approximately 10 years old. Early PA practice laws required the supervising physician to be the PA's employer. As a result, the Medicare statute required that reimbursement for the medical care provided by PAs be made to the PA's employer.

As the need for providers and the understanding of the PA profession expanded, Medicare coverage of medical care provided by PAs was also gradually expanded to include medical services in Medicare-certified health maintenance organizations (1982); services provided in skilled nursing facilities, hospitals, and assisting at surgery (1986); and services provided in rural health manpower shortage areas (1987). In 1997,

Congress authorized coverage of services provided by PAs, as allowed by state law, in all settings, and at a uniform rate. Unfortunately, barriers still remain.

As the profession has matured, PAs have moved from physicians' outpatient clinics into hospitals, group practices and other business entities. Today, PAs are employed across the spectrum of medical settings and typically practice with physicians who are not their employers. State practice laws also have expanded the role of PAs, and many states have passed laws allowing PAs to own medical practices. In states that permit PAs to be sole owners of a medical practice, a PA-owned practice entity can structure its relationship with an employed or contracted physician in a manner that preserves the role of the physician as clinical supervisor. In many of these clinics, particularly in rural areas, the physician may be available electronically, rather than physically, for consultation.

Not a single state law currently links the role of a PA's supervising physician with a PA's employer. However, the Medicare statute continues to require that payment for medical care provided by PAs be made to the employer or to a PA owner of a federally certified rural health clinic (RHC). Neither does state law restrict a PA from ordering and providing hospice and home health care. The Medicare payment restriction linking reimbursement to the PA's employer is not imposed on any other healthcare professional who is authorized to provide medical care through the program, including physicians, nurse practitioners, psychologists, clinical social workers, speech and language pathologists, dietitians, physical therapists, etc. In the case of ordering and providing hospice and home healthcare, Medicare imposes barriers on access to care provided by PAs that do not exist in state law.

Implications for Patients and the Healthcare System

Patient Access

The current payment restriction for medical care provided by PAs has created patient access problems as the PA profession has matured and as healthcare systems and new models of care have become increasingly dependent upon PAs. For example,

- A hospice patient in rural Utah received medical care from a PA who was the sole primary care provider for his community. The PA was forced to take the patient out of in-home hospice care and admit her to a small community hospital to manage her pain. Because the PA was not authorized to provide hospice care by Medicare, the patient was hospitalized instead of being at home where she would have preferred to be and utilized one of seven available beds in the hospital.
- Needed home healthcare was delayed over a week for a Medicare patient in Nevada, because the physician with whom the PA worked was located 60 miles away. The PA, who holds a full-time job in another part of the state, is the sole healthcare professional for the patient's small rural town, providing care two weekends a month.
- A Medicare patient who was scheduled for cardiovascular surgery at a major teaching facility in Virginia decided to opt for hospice care instead of the scheduled surgery. The patient remained in the hospital's intensive care unit for three days before the PA could obtain the surgeon's signature for hospice certification.

Transparency & Accountability

The current payment system limits the Medicare Program's ability to fully track the volume and quality of medical and surgical services provided with Medicare dollars, as well as to assess the impact of the services on patient care.

- Medical practices solely owned by PAs may not be issued National Provider Identifiers (NPIs). Consequently, the practices may not be reimbursed for covered services provided to Medicare beneficiaries – even though state law allows PAs to own corporations, and the states desperately need additional Medicare providers. Alaska is one example of a state that contains many

medically underserved areas, heavily relies on PAs to provide primary medical care, and allows PAs to own medical practices. Alaska needs additional Medicare providers, but the current restriction will not allow PA-owned practices in Alaska to be reimbursed for covered Medicare services.

- PA-owned RHCs receive payment for RHC cost-based expenses, but the PA owner/practitioner may not bill for certain other covered services, which the clinic is required by law to provide and that would otherwise be separately billable under Medicare, unless he/she establishes a separate corporation that meets the Centers for Medicare and Medicaid Services' (CMS) interpretation of the law's current payment restriction. Inpatient hospital services provided by the PA owner, as well as basic lab tests, such as chemical examination of urine by stick or tablet method, hemoglobin or hematocrit, blood sugar, examination of stool specimens for occult blood, and pregnancy tests are all required services, but fall outside of the RHC cost-based reimbursement.
- A baseline for medical care provided by PAs will become increasingly important as the healthcare system moves towards a model that relies more on team-based delivery of care, requires evidence-based clinical benchmarks, and demands reliable and accurate patient data.

The Medicare program has provided reimbursement to practices in which PAs share ownership since 2003. However the statutory language restricting payment to the employer of the PA has been interpreted by CMS to deny NPIs to medical practices solely owned by PAs. PA-ownership of medical practices in rural communities often results from a PA assuming ownership of a medical practice from a retiring physician with arrangements for clinical oversight provided by a physician from a neighboring town.

Modernizing the Payment System

Updating the Medicare payment system to treat PAs the same as all other healthcare professionals reimbursed under the Medicare statute can be accomplished by:

- Amending Sec. 1832(a)(2)(B) to add the services of a physician assistant;
- Adding a conforming amendment by amending Sec. 1842(b)(6)(3) to clarify that payment may be made to the physician assistant, the employer of the physician assistant, or the physician assistant owner of a rural health clinic.
- Amending Sec. 1814(a)(7)(A) to permit PAs to order hospice care.
- Amending Sec. 1861(dd)(3)(B) to provide authority to PAs to provide hospice care.
- Amending Sections 1814(a), 1835(a), 1861(m), 1861(o)(2), and 1895 to allow PAs to order home health services.

Conclusion

PAs have been part of the healthcare workforce for more than 40 years. As experience with physician-PA teams grows, laws are being modernized to reflect the current understanding of the broad scope of high quality medical care provided by PAs and the growing need for quality providers. Adopting best practice language into laws and regulations enables PAs and physicians to extend care to patients more effectively. Additionally, any time PAs are treated differently, it creates a disincentive in the healthcare marketplace to utilize PAs. Updating Medicare's payment system to treat PAs the same way as all other healthcare providers will enable greater access to the quality medical care provided by PAs, particularly in medically underserved areas; allow for greater flexibility and efficient utilization of PAs, and provide for increased transparency regarding the medical care, cost, and outcomes of covered Medicare services provided by PAs.