November 12, 2013

Chairman Max Baucus
Committee on Finance
U.S. Senate
Washington, DC 20510

Ranking Member Orrin Hatch
Committee on Finance
U.S. Senate
Washington, DC 20510

Chairman Dave Camp
Committee on Ways and Means
Washington, DC 20515

Ranking Member Sander Levin
Committee on Ways and Means
Washington, DC 20515

Dear Chairmen Baucus and Camp and Ranking Members Hatch and Levin:

On behalf of the more than 93,000 physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit comments on the bipartisan, bicameral discussion draft prepared by the Senate Finance Committee and House Committee on Ways and Means to repeal and replace the flawed Sustainable Growth Rate (SGR) formula used to reimburse Medicare-covered services. This proposal offers great promise to provide long-sought stability to the Medicare program, benefitting Medicare beneficiaries and the healthcare professionals who serve them.

AAPA applauds your leadership in developing a framework for Medicare payment reform that rewards value over volume and creates incentives for healthcare professionals and medical practices to move from the fee-for-service payment system toward alternative payment models, such as medical homes, accountable care organizations, and bundled payments. AAPA appreciates that the draft includes PAs as healthcare professionals that can participate in alternative payment models (APMs), recognizes the role of PAs in providing complex chronic care management services and includes PAs as an eligible healthcare professional for the value-based performance (VBP) payment program. This is important as PAs are playing a growing role in care coordination and are uniquely suited, due to their commitment to the patient-centered team practice model, to manage the provision of high quality care for their patients.

It is very important that the SGR replacement treat PAs in the same way as physicians and nurse practioners (NPs), including provisions related to quality measures, clinical practice improvement activities, performance assessment, and transparency initiatives. A failure to treat PAs in the same manner as physicians and NPs typically results in negative consequences for patients and our healthcare system, including inhibited access, disruption in the continuity of care for patients whose primary healthcare professional is a PA, employment disincentives for hiring PAs and added costs to the healthcare delivery system. AAPA strongly recommends the legislative language that results from the discussion draft fully, expressly and equally integrate PAs throughout the reformed payment system.

PAs are committed to moving forward with the Committees towards new payment models that reward value and quality over volume. However, if these models are to be successful, particularly in rural and underserved areas, it is absolutely critical the Medicare payment system is updated to remove outdated barriers that

prevent providers from providing needed care for their Medicare patients. In order to utilize PAs to the top of their education, experience and license, AAPA believes the Medicare payment system should be updated to treat PAs in the same manner as all other healthcare professionals reimbursed through the program by incorporating the legislative changes described below into a modernized Medicare program.

Allow direct Medicare reimbursement to PAs. One example of a problematic barrier that impacts our patients in rural areas is outdated Medicare language that reimburses a PA's employer rather than the PA for treatment provided by a PA. This language is a problem in rural and medically underserved areas in states where PAs may own their own clinic and act as the employer. As a consequence, PA-owned medical practices are unable to apply for their own NPI number to seek reimbursement for providing care to Medicare patients. This creates unnecessary barriers, including inefficient workrounds, for the full utilization of PA-owned clinics in areas where there is a growing need and limited access for Medicare services. If payment system reforms are to be successful, we will need to grow the number of practitioners dedicated to coordinated patient-centered care in rural and underserved areas. All other providers in the Medicare system may be paid directly for their services. PAs should be permitted to receive direct payment in the same manner as other providers, such as physicians, NPs, psychologists, clinical social workers, speech and language pathologists, dieticians, and physical therapists, etc. This reform can be accomplished by adding services of a physician assistant to Sec. 1832(a)(a)(B) of the statute and by a conforming amendment to 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.

Allow PAs to order home health services for their patients. Another outdated barrier is the Medicare limitation on a PA's authority to prescribe and manage home healthcare for their patients. Requiring PAs to seek a physician's signature to authorize treatment for a patient the physician may have never treated is an added expense to the system and a barrier to efficient and timely care for patients. Cost estimates received from outside estimators between 2009-2012 have scored this provision at little or no cost. This could be corrected by amending Sec. 1814(a), 1835(a), 1861(m), 1861(o)(2), and 1895 to permit PAs to order home health services.

Align EHR meaningful use requirements and incentives in ways that do not penalize PAs who have had statutorily limitedability to access EHR incentive payments. AAPA is concerned about the role of Electronic Health Record (EHR) Meaningful Use as an assessment category for the VBP program since PAs have not been eligible in the past for Medicare EHR incentives. One unintended consequence of PAs not being eligible for the Medicare EHR incentive, along with a very limited eligibility for the Medicaid EHR, was as an employment disincentive for medical practices to hire PAs. Additionally, medical practices that heavily utilized PAs may have had more difficulty moving to electronic health record systems without the benefit of incentives. Accordingly, AAPA encourages the committees to ensure that PAs' inability to utilize the Medicare EHR incentive not penalize the PA profession in quality measures based on EHR meaningful use.

Avoid provisions that appear to limit utilization, but in reality only create administrative and access barriers that are unworkable and inconsistent with the goal of improving efficiency and moving toward Advanced Payment Models (APMs). The Academy also recommends that all healthcare professionals be responsible for the quality and resource utilization for the medical care they order and/or provide. Unfortunately, recent regulatory requirements and interpretations of congressional requirements limited the number of healthcare practitioners who can order clinically appropriate care and services and/or to require a physician certification for the order. AAPA believes that requiring physician certification for services is counterproductive in today's healthcare delivery system. Our current healthcare system relies heavily on PAs to provide medical care, and PAs are the principal healthcare professional for many patients, particularly patients in rural and medically underserved communities. The physician certification requirement adds an unnecessary administrative burden, and added cost, for physicians to certify care for patients. We strongly encourage the Committees to increase efficiency by avoiding future legislative language that would create

further inefficient provisions of care through physician certification requirements. These types of provisions are particularly unsupportable in new payment models, such as bundled payments, in which inappropriate utilization of care is not rewarded. These new models create a unique opportunity to revise Medicare law to allow PAs and other healthcare practitioners to be accountable for the orders they initiate and the services they deliver.

Improve the continuity of care and lower costs by allowing PAs to provide and order hospice care. As you move to the next step in the process of legislating meaningful payment reform, we raise for your consideration a provision that may achieve the dual goals of improved efficiency and access. PAs absolutely must be able to both provide and manage hospice care. The inability of PAs to provide and manage hospice care creates a continuity of care dilemma for our patients when they are at their most vulnerable. Patients who have PAs as their primary care provider lose a trusted caregiver at the time that they need them most. Amending Medicare to reimburse hospice care provided by PAs would not only right a wrong, but AAPA expects this would also decrease costs by removing costly work arounds to manage pain medications and by encouraging the provision of hospice care at home.

Recently, for example, a story was shared with us of a hospice patient in rural Utah who 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. Because of this provision, 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 rural hospital. In a similar recent story, a PA shared the story of her Medicare patient who was scheduled for cardiovascular surgery at a major teaching facility in Virginia. The patient changed her mind and asked for hospice care instead of the scheduled surgery. This decision resulted in the patient remaining in the hospital's intensive care unit for three days due to the difficulty in obtaining the surgeon's signature for hospice certification. This can be fixed by permitting PAs to treat their patients who are ready to move to the next phase of care and into hospice by amending Sec. 1861(dd)(3)(B). to provide authority for PAs to provide hospice care and amending Sec. 1814(a)(7)(9)(A) to permit PAs to order hospice care.

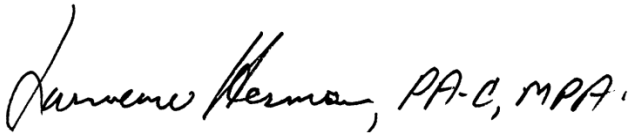
Improve transparency in how federal health care dollars are spent by explicitly tracking medical care provided by PAs. Finally, AAPA believes it is essential to provide transparency regarding the medical care, cost and outcomes of care provided by PAs. Updating the Medicare statute to reimburse PAs in the same way as all other healthcare professionals are reimbursed through the program is a critical fist step. However, AAPA believes additional system reforms are necessary, including the use of a modifier to track the medical care and cost of care provided by PAs. Additionally, AAPA believes it is critical that EHR systems utilized by Medicare providers, including new delivery models such as ACOs and medical homes, and established medical practices, hospitals, nursing homes, etc., are capable of tracking medical care provided by PAs. The Academy believes that a requirement of Medicare data systems to track medical care provided by PAs is essential to track the clinical and economic performance of PAs for issues related to cost-effectiveness, quality, and outcomes research; practice patterns; and to determine the volume of patient care services delivered for workforce projections. Accordingly, AAPA recommends that the ability to track medical care provided by PAs, as well as the cost of medical care provided by PAs, be required as a standard in EHR meaningful use.

AAPA encourages the Committees to add these provisions to SGR reform, believing that new payment models, particularly bundled payments, should not be limited by outdated Medicare policy that restricts which qualified healthcare professionals may order needed care or provide needed care.

Again, thank you for the opportunity to provide comments on the bipartisan, bicameral discussion draft to repeal and replace the SGR. AAPA applauds your leadership in developing consensus on a framework for Medicare payment reform and looks forward to working with you to develop legislation. Please do not

hesitate to have your staff contact Sandy Harding, AAPA senior director of federal advocacy at sharding@aapa.org or 571-319-4338 with questions regarding the PA profession or the Academy's comments.

Sincerely,



Lawrence Herman, PA-C, MPA
AAPA President