



May 1, 2023

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: AAPA Comments Regarding the End of the Public Health Emergency

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 168,300 PAs (physician assistants/associates) throughout the United States, would like to provide to the Centers for Medicare and Medicaid Services (CMS) comments regarding the upcoming expiration of the public health emergency (PHE).

In response to the COVID-19 pandemic, CMS authorized numerous regulatory changes and flexibilities to increase patient access to care and protect both patients and healthcare professionals. Some of these regulatory relief measures were identified as temporary, lasting only through the duration of the PHE. However, as the COVID-19 crisis accentuated the importance of America's healthcare work force being able to practice to the full extent of their education and experience, we were pleased that several of the policies increasing PA practice flexibility have now become permanent. Our comments below reflect AAPA's observations regarding which outstanding flexibilities should be made permanent to maintain advances in the efficient delivery of care to patients, which flexibility should not be made permanent, and additional flexibilities that should be considered in light of lessons learned from the pandemic. For your convenience, we have divided our letter by the action we propose, as well as by topic.

PHE Flexibilities That Should Be Made Permanent

Authorize PAs to Provide Physician-Required Services in Skilled Nursing Facilities

For years, PAs have been authorized to deliver care to Medicare beneficiaries in SNFs. However, PAs are not recognized by Medicare for the purposes of performing the comprehensive visit to SNF patients. Also, PAs

are required to alternate every other required visit to SNF patients with physicians. These restrictions were not based in medical evidence but were merely a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system. During the COVID-19 PHE, CMS authorized the delegation of “physician-only” visits in SNFs to PAs, if there was no conflict with state law or facility policy. AAPA sees no clinical justification for re-instituting these outdated practice restrictions when years of experience have demonstrated the high-quality care PAs deliver in SNFs. During the PHE, SNFs, as a result of decreased time spent by patients in hospital settings, felt extraordinary strain and saw worsening results that would have been more severe if CMS had not granted the ability of PAs to ameliorate access burdens. PAs remain clinically prepared, educated, and competent to deliver the full range of needed clinical care in SNFs. When PAs are authorized to deliver care to the full extent of their education and state law scope of practice, patient access to care is improved, especially in rural and underserved communities.

Regulatory requirements in SNFs necessitate physician involvement that may not be readily available in rural settings, or available in a timely fashion in high-demand settings. Allowing PAs to provide these services will expand patient access to needed care, as patients will no longer have to wait to see a physician when a PA is available.

AAPA requests that CMS permanently eliminate policy that mandates that certain visits in SNFs be furnished only by a physician. PAs should be authorized to perform the comprehensive visit, as well as to perform all required visits, in SNFs.

Allow Care in Hospitals to be Under the Care of a PA

During the PHE, CMS waived requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) that require Medicare patients be under the care of a physician. Consequently, inpatient Medicare beneficiaries were able to be under the care of a PA. PAs provide care in teams with physicians and other healthcare professionals, and there is nothing in statute or in the medical evidence that would preclude a hospitalized patient from being “under the care of” a PA.

Authorizing patients to be under the care of a PA would eliminate outdated regulations that make delivering care less efficient. For example, the requirement that every Medicare beneficiary be “under the care of a doctor” in a hospital has led to an interpretation that when an authorized health professional other than a physician writes an order for admission, a physician must co-sign it. Medicare policy permits PAs to determine the necessity of an inpatient hospital admission, write the admission order, and perform the accompanying history and physical examination. Despite this, the CMS requirement for a patient to be under the care of a physician and the additional unnecessary requirement of a physician co-signature, potentially days after a PA’s determination of medical necessity, is an inefficient use of a physician’s time and does not lead to higher quality care for beneficiaries. Furthermore, if a physician is not available, the patient’s discharge from the hospital may be delayed, resulting in an increased length of stay in the hospital and increased cost to the Medicare or Medicaid programs.

Authorizing a patient to be “under the care of” a PA would provide the same collaborative and coordinated care as has been traditionally provided in hospitals without imposing arbitrary administrative burdens. Despite what some stakeholders may assert, there is no known difference in quality or outcomes when collaborative care is “under the care of” a physician or a PA. In fact, a 2019 report by the Medicare Payment Advisory Commission (MedPAC) concluded that “a large body of research, including both randomized clinical trials and retrospective studies,” demonstrates that care provided by PAs “produces health outcomes that are equivalent to physician-provided care.” In addition, there are facility safeguards to ensure that quality care is delivered to beneficiaries, regardless of whether a patient is under the overall care of a PA or physician. For example, value-based payment and public reporting measures, facility by-laws and privileging requirements and other measures will ensure that high-quality and safe care is provided.

AAPA requests that CMS change 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) to authorize Medicare patients in the inpatient setting to be under the care of a PA.

PHE Flexibility to Discontinue

Authorization for Direct Supervision by Real-time, Audio/Video Technology for Certain Health Professionals

Direct supervision is the level of supervision Medicare requires for “incident to” billing, some diagnostic tests, and certain other services. Direct supervision requires the supervising health professional to be immediately available (in-person, but not in the same room) to the professional delivering care. During the PHE, CMS indicated through IFC 1744¹ that direct supervision requirements could be met by the supervising clinician being available via audio/visual (real-time, interactive) communication. This flexibility was granted to minimize the transmission of COVID-19, meet the increased needs of patients, facilitate the utilization of telehealth, and mitigate the risk of patients not receiving timely medical care during a pandemic. CMS has elected to not move forward with making the temporary exception permanent and virtual direct supervision is scheduled to end on December 31, 2023. However, the agency has recently sought feedback for further consideration on the matter.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 PHE. We recognized that this flexibility was necessary to minimize exposure to COVID-19 and reduce detrimental impacts of the pandemic on the timely provision of care. However, at the same time we were concerned about the negative impact of such a policy on transparency and data collection efforts, and on increased costs to the Medicare program.

AAPA continues to have significant concerns regarding “incident to” billing for services provided by PAs/NPs and the transparency complications that come with it. As you are aware, “incident to” is a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to us is “incident to” billing pertaining to services performed entirely by

¹ <https://www.cms.gov/files/document/covid-final-ifc.pdf>

PAs and NPs that are attributed to a physician. Due to the manner in which services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services delivered to Medicare beneficiaries by PAs and NPs may be attributed to physicians with whom they work. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services delivered by PAs and NPs. Accurate data collection and appropriate analysis of workforce utilization is lost. This lack of transparency has a negative impact on patients, health policy researchers, the Medicare program, and PAs/NPs.

One of the key issues in ensuring that healthcare 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. “Incident to” billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the MSN/EOB notice. When medical care provided by a PA is billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who was not seen by the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Physician Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals with an assessment of the professional’s overall quality of care based on a Medicare computed performance score. When services performed by PAs are hidden due to “incident to” billing, not only is Medicare unable to determine accurate PA quality scores, but these scores may not appear on the Physician Compare site if the health professional does not exceed the low-volume threshold because of a limited number of services being attributed to them. In addition, if PAs have all their services billed under “incident to,” those PAs may not appear on the Physician Compare website. PAs not being identified on Physician Compare, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a healthcare provider.

With a substantial number of services provided by PAs and NPs attributed to physicians in “incident to” billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research performed using such data is inaccurate due to a lack of attribution to the PA or NP who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distort the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies. Under “incident to” billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care, and resource use allocation.

MedPAC, in its report released on June 14, 2019, noted the increasing role of PAs and NPs in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and NPs was billed

“incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.² Similarly, in CMS’s 2019 Physician Fee Schedule final rule, the agency acknowledged that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services “incident to” a physician when furnished by a PA or NP.³ The absence of data attributed to PAs and NPs 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. Similar concern regarding the negative impact of “incident to” billing on the accuracy and validity of value-based programs has been echoed in the Health Affairs Blog in a January 8, 2018, posting.⁴ 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 productivity, and economic and clinical value can influence the analysis of PA/NP healthcare contributions.

AAPA is concerned that CMS authorizing direct supervision requirements by audio/visual communication would only make it easier to use “incident to” billing, thereby leading to expanded use of the billing mechanism. This would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional.

Consequently, due to our ongoing concerns with “incident to” billing and its harm to transparency, AAPA instead suggests that direct supervision by audio/visual communication be allowed only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for these health professionals, such as registered nurses, medical assistants, and technicians, will allow for expanded patient access to care as it will increase flexibility in supervisory requirements for such professionals to perform their duties while not having an adverse impact on transparency. PAs and NPs are able to provide and bill for services under their own names instead of a physician’s name, and at a lower cost of care (reimbursement rate) to the Medicare program. An extension of direct supervision by audio/visual communication for PAs and NPs would only serve to further impair data transparency through the potential proliferation of “incident to” billing.

AAPA strongly encourages that CMS not authorize direct supervision by real-time, audio/video technology for medical services performed by PAs and NPs.

Additional Lessons from the PHE

The Need to Increase Access to Behavioral and Mental Healthcare

The CMS 2023 Physician Fee Schedule proposed rule correctly identifies the pandemic as exacerbating existing barriers to behavioral/mental healthcare at a time of increasing demand. However, AAPA cautions

² <https://www.medpac.gov/document-type/report/>

³ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>

⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20180103.135358/full/>

that just because the PHE declaration is ending does not mean the burdens of the pandemic on the health system will recede. Specifically, access to behavioral/mental healthcare is expected to continue to be a problem due to increased demand and worsening workforce shortages.

Mental and behavioral health, much like healthcare generally, is experiencing worsening provider shortages, compounding already existing access issues. Sixty percent of US counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health treatment and contributing to inadequate care and unsafe conditions.⁵ A recent New York University study found that while demand for mental health services is increasing, patient access is decreasing.⁶ Untreated mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.⁷

The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than needed to meet the demand for services.⁸ 156 million people live in communities with limited access to mental healthcare services.⁹ The National Council for Behavioral Health expects that, by 2025, there will be a deficit of 12% in the psychiatric workforce to sufficiently address patient needs.¹⁰ An inadequate supply of providers of mental health services may lead to delays in diagnosis and care, rationing of resources, ineffective care, and increased negative consequences of mental illness and substance use.¹¹ These problems will be further magnified in rural and underserved areas.

Increased practice flexibilities for behavioral health professionals will have a positive impact in addressing such access issues. All qualified health professionals must be authorized to practice to the fullest extent of their license and training. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

PAs are trained and qualified to treat mental and behavioral health conditions through their medical education, including didactic instruction and clinical practice experience in psychiatry and other medical specialties, and have national certification, state licensure, and authority to prescribe controlled and non-

⁵ Substance Abuse and Mental Health Services Administration. 2019. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>

⁶ Heath, Sara. PatientEngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. Retrieved from <https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows>

⁷ Mayo Clinic. 2019. Mental Illness. Retrieved from <https://www.mayoclinic.org/diseases-conditions/mentalillness/symptoms-causes/syc20374968#:~:text=Untreated%20mental%20illness%20can%20cause,Family%20conflicts>

⁸ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. Rockville, Maryland. Retrieved from <https://www.hrsa.gov>

⁹ <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

¹⁰ National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. Retrieved from <https://www.thenationalcouncil.org>

¹¹ Ibid

controlled medications.¹² PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral health services. Based on their graduate level medical education, PAs practicing in mental health and substance use treatment can expand access to necessary care. PA education includes more than 2,000 hours in clinical rotations, including experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan from pediatrics to geriatrics, providing a foundation to address the diverse medical needs of people with mental illness or substance use issues.¹³

PAs perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans, and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists.¹⁴ In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs, working with other members of the healthcare team, have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to that of physicians.¹⁵ Payers authorizing PAs to deliver this high-quality care to patients, such as is allowed under fee-for-service Medicare, can alleviate ongoing and worsening trends in access to behavioral and mental health services.

PAs work to ensure the best possible care and outcomes for patients in every specialty and setting, interacting with patients with mental and behavioral conditions in psychiatry, family medicine, internal medicine, emergency medicine, and other specialties.

The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics, with a projected 31% increase in PAs from 2018 to 2028.¹⁶ This growth projection, along with PAs' qualifications, suggest that the increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

The number of PAs practicing in psychiatry has remained low due to restrictions placed on PAs by some payers. However, the recognition of PAs as qualified providers of mental and behavioral health services can

¹² American Academy of PAs. What is a PA? Retrieved from <https://www.aapa.org/what-is-a-pa/>

¹³ Ibid

¹⁴ Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. American Journal of Preventive Medicine. 2018. Geographic variation in the supply of selected behavioral health providers. Retrieved from [https://www.ajpmonline.org/article/S0749-3797\(18\)30005-9/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext)

¹⁵ Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from <https://www.medpac.gov>

¹⁶ U.S. Bureau of Labor and Statistics. 2020. Occupational outlook handbook: Physician assistants. Retrieved from <https://bls.gov>

increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act,¹⁷ CMS's inclusion of PAs as authorized providers in community mental health centers,¹⁸ and the establishment of PAs as mental and behavioral health providers at the state level.

While Medicare, many state Medicaid programs, and commercial payers cover behavioral and mental health services provided by PAs, some private payers, many of which interact with Medicare and its beneficiaries, do not. Private payers should authorize payment for all behavioral and mental health services provided by PAs that are performed in compliance with state law.

Private payers removing outdated policies that may act as barriers to behavior and mental healthcare will allow for greater utilization of the PAs that currently practice in behavioral health, as well as encourage a greater number of PAs to practice in psychiatry and related specialties. The increased demand for behavioral and mental health services requires the contribution of all qualified health professionals without outdated restrictions, which have not been demonstrated to be needed, constraining access to care.

AAPA requests that CMS strongly encourage all payers who provide a plan under the purview of the agency, such as Medicare Advantage Plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies regarding PAs providing behavioral/mental health services. This would align the behavioral health policies under these plans with Medicare, and ensure beneficiaries covered by such plans have more qualified care options available to them.

The Need for Greater Flexibilities in the Waiver of Facility Policies and Bylaws During a PHE

AAPA would like to again thank CMS regarding the various flexibilities implemented during the COVID-19 PHE. These flexibilities ensured health professionals could practice safely and efficiently while meeting increased demands. However, AAPA has reason to believe that some waivers and flexibilities were not taken advantage of because of the manner in which hospital policies were written in order to conform with Conditions of Participation (42 CFR § 482.22(c)). One example of a flexibility we believe to not have been fully utilized due to regulatorily required bylaws may be the authorization for patients to be “under the care of” a PA, as opposed to under the care of a physician, a flexibility intended to increase patient access. Consequently, despite Medicare allowing increased flexibility nationally, health professionals in facility settings may not have been able to act on such flexibilities due to internal constraints that cannot be expeditiously addressed.

AAPA requests that CMS institute an explicit policy to be used in times of a PHE that would allow facilities to temporarily waive their own policies and bylaws when seeking to comply with federal

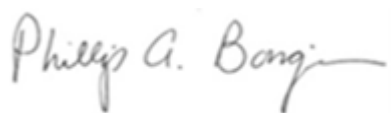
¹⁷ 21st Century Cures Act. Public Law No: 114-255 2016. Retrieved from <https://www.congress.gov/bill/114th-congress/housebill/34/text>

¹⁸ Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. Retrieved from <https://www.law.cornell.edu/cfr/text/42/485.904>

flexibilities directly related to a waiver. To authorize this, CMS should modify §482.22(c), which requires medical staff to adopt and enforce bylaws, to allow for targeted waiving of requirements to align with federal flexibilities. In addition, we ask CMS to encourage states and accrediting agencies with similar requirements to waive such constraints as well during public health emergencies. This would help ensure federal flexibilities are being implemented as intended.

Thank you for the opportunity to provide observations on a number of policy considerations related to the expiration of the PHE. AAPA welcomes further discussion with CMS regarding these issues. For any questions you may have please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at michael@aapa.org.

Sincerely,

A handwritten signature in black ink that reads "Phillip A. Bongiorno". The signature is written in a cursive style with a long horizontal flourish at the end.

Phillip A. Bongiorno
Senior Vice President
Advocacy and Government Relations