American Academy of PAs

May 28, 2024

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

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program

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 comments on the 2025 Inpatient Rehabilitation Facility (IRF) Prospective Payment System proposed rule.

AAPA recognizes that the proposed rule released by CMS consists largely of technical adjustments. However, AAPA urges CMS to, as it seeks to implement policies to better improve IRFs, revisit its previous proposed policies of authorizing PAs and NPs to provide care in these settings without unnecessary restrictions.

One provision of the proposed rule makes changes to the IRF Quality Reporting Program to improve reporting on social determinants of health. According to the rule, social determinants of health are "socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health." This information is often collected to support improved health outcomes through the recognition and possible remediation of confounding factors. AAPA supports these efforts, and, in this spirit, simultaneously encourage CMS to look again at impediments to care access of which it has immediate control: regulatory restrictions that put frequency limitations on when certain health professionals can provide care to patients.

Currently, §412.622(a)(3)(iv) identifies the need to conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality and to modify the course of treatment as necessary. However, language contained in this section of the CFR also requires that for the first week, a physician must do all three, and in each subsequent week, a non-physician health professional such as a PA or nurse practitioner (NP) may only do one of the three visits per week. In addition, section, §412.622(a)(4)(ii), requires a rehabilitation physician to develop a plan of care for a patient within four days of admission. Requiring a physician to perform these duties is inefficient. PAs and NPs are qualified to provide these services in full in order to meet patient demand. Such restrictive policies may also impact patient treatment if a patient is required to wait to see a physician for care that another health professional is qualified to provide.

To address concerns of regulatory burdens in IRFs and ensure an adequate healthcare workforce in these settings, CMS had previously expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs to fulfill many of the medical responsibilities previously assigned only to rehabilitation physicians. AAPA supported CMS's proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician only" requirements. Unfortunately, CMS did not ultimately choose to finalize the flexibilities as initially proposed, and maintained physician-centric language in its policies.

AAPA requests that CMS reassess IRF policies for the potential removal of physician-centric language. CMS should authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law. PAs have the appropriate training to ensure that IRF patients will continue to receive high-quality care when services are provided by PAs. CMS shows its agreement in its authorization for PAs to provide one of the three weekly required visits.

PAs provide high-quality care that is comparable to that provided by physicians.[1, 2, 3] PA-provided care has lower rates of medical malpractice and adverse outcomes than that of physicians.[4] Beneficiaries prioritize receiving high-quality care, irrespective of the title of the health professional who provides that care. PAs have been shown to provide high-quality care, and patients have consistently indicated high levels of satisfaction with PAs, comparable with care delivered by physicians.[5] Patients have demonstrated confidence and trust in the PA profession by indicating the type of health professional who provides care is less important than when they obtain access to quality care.[6]

Decisions regarding which qualified health professional provides care to a patient should be made according to IRF staffing needs, and not hamstrung by arbitrary limitations on available care options. Granting an expanded authorization in this setting would not impose a requirement on IRFs, but rather give rehabilitation facilities maximum flexibility by providing them with the option to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation workforce that provides patients with timely access to care. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients.

Thank you for the opportunity to provide comments regarding the 2025 Inpatient Rehabilitation Facility Prospective Payment System proposed rule. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact me at michael@aapa.org.

Sincerely,

Michael L. Powe, Vice President
Reimbursement and Professional Advocacy

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[1] https://pubmed.ncbi.nlm.nih.gov/31145882/
[2] https://pubmed.ncbi.nlm.nih.gov/30458506/
[3] https://pubmed.ncbi.nlm.nih.gov/28234756/
[4] https://journals.sagepub.com/doi/10.1177/1077558716659022
[5] https://pubmed.ncbi.nlm.nih.gov/31881896/
[6] https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1150