September 9, 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 and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities - Attention: CMS-1786-P

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 178,000 PAs (physician assistants/physician associates) throughout the United States, would like to provide comments on the 2025 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems (OPPS), et al, proposed rule. PAs currently provide hundreds of millions of patient visits each year, and many of those visits are with Medicare beneficiaries. As such, PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies in the proposed rule.

AAPA seeks to work in partnership with the Centers for Medicare and Medicaid Services (CMS) to advance policies that increase access to high-quality care for all Medicare beneficiaries. It is within this context that we draw your attention to our comments.

Expansion of Colorectal Screenings

In the 2025 OPPS, CMS makes multiple proposed changes to expand coverage of colorectal cancer screenings. These include adding coverage of computed tomography colonography (CTC), expanding Medicare's approach to

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“complete colorectal cancer screening” to include a blood-based biomarker test alongside a non-invasive stool-based test, and indicating that follow-on colonoscopies would not incur beneficiary cost sharing. AAPA broadly approves of efforts to increase access to care that might provide early detection of treatable illnesses. AAPA also appreciates explicit mention in the rule of the ability of PAs to order CTC. We recognize that CMS has proposed many provisions in recent years that have sought to expand coverage for colorectal screenings. However, AAPA notes there are other barriers to colorectal cancer screenings that, when removed, would increase access to these services. Specifically, CMS should further increase access to colorectal cancer screening procedures by authorizing PAs to order immunoassay (or immunochemical) fecal occult blood tests (iFOBT) and blood-based biomarker tests and perform colonoscopies.[1]

PAs are authorized (42 CFR 410.32(a)(2)) to order and interpret Medicare-covered diagnostic laboratory tests. As such, requiring a physician order is unnecessarily administratively burdensome. The requirement for a patient to receive an order from a physician may interrupt the efficient provision of care by forcing the patient to seek a separate appointment with a physician. These increased visits may produce extra financial burdens on the patient, affecting those underserved patients most acutely.

The condition that colonoscopies be performed only by a doctor of medicine or osteopathy may lead to unnecessary delays in patient care to meet the requirements that a physician perform the procedure. This delay when other health professionals are qualified to perform this service is inefficient and may negatively affect patient outcomes. No such limitation on the type of provider is included in the Social Security Act[2] and PAs have demonstrated the competency to perform colonoscopies, including biopsies when medically necessary, comparable to gastroenterologists in technical performance and quality metrics. Specifically, a study[3] demonstrated there were no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies, and that “this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies.”

The increased demand for colonoscopies due to more patients being eligible for the procedure because of earlier recommended screening ages and the eventual removal of patient coinsurance for Medicare beneficiaries when there is a need for associated procedures along with the screening colonoscopies, will place a serious strain on the availability of colonoscopy services. The increased demand for colonoscopies will likely have a disproportionately

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[1] Centers for Medicare and Medicaid Services. 2023. Medicare Claims Processing Manual, Chapter 18. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf
[2] Social Security Administration. Part E – Miscellaneous Provisions. Definitions of Services, Institutions, etc. May 2024. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[3] Fejleh, M. Phillip MD; Shen, Ching-Chieh MD; Chen, Jacqueline MD; Bushong, Joseph A. PA-C; Dieckgraefe, Brian K. MD, PhD; Sayuk, Gregory S. MD, MPH. Quality metrics of screening colonoscopies performed by PAs. *Journal of the American Academy of Physician Assistants*. April 2020. 33(4): 43-48, DOI:10.1097/01.JAA.0000657192.96190.ab. https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx

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negative impact on rural populations obtaining access to this important preventive service. This lack of access would be counterproductive to CMS's goal of increased health equity. Consequently, AAPA recommends that CMS authorize PAs to perform colonoscopies.

AAPA requests that, in alignment with other efforts to expand patient access to colorectal cancer screenings, CMS authorize PAs to order immunoassay (or immunochemical) fecal occult blood tests (iFOBT) and blood-based biomarker tests and perform colonoscopies.

Inclusion of PAs within Obstetric Conditions of Participation

Perhaps no area of medicine has gained as much attention over the last few years than reproductive healthcare, including peripartum and postpartum health. PAs have a rich history of providing obstetric health as part of a reproductive healthcare team. PAs in obstetrics in inpatient settings typically fit one of two models— either they are employed outside the hospital and have privileges to provide inpatient care or they are employed as staff on OBGYN services. The PAs perform histories and physicals on patients admitted to the service, consultations, and daily rounds. They update and educate patients and families about courses of treatment and management plans. PAs write orders for admission, discharge, transfer, pre- and post-operative care, and laboratory and diagnostic tests. They arrange for studies or procedures, request consultations, and write discharge summaries and prescriptions. PAs perform amniotomies, place internal monitors, and interpret fetal monitor strips. They perform ultrasound, colposcopy, cryotherapy, IUD and Nexplanon insertion and removal, endometrial and vulvar biopsies, and loop excision electrocoagulation procedure (LEEP). PAs in labor and delivery monitor patients, perform pelvic examinations to evaluate the course of labor, perform uncomplicated vaginal deliveries, and assist with operative vaginal deliveries and Cesarean-sections. PAs often share call for deliveries, particularly in rural areas where there may be few providers.[4]

With that in mind, AAPA commends CMS for its proposed new sections 482.59 and 485.649 of the CFR for hospitals and community access hospitals offering obstetrical services outside of an ED.

These proposals seek to raise the standards of facilities across the country at a time when reproductive healthcare is in need of reform. The Academy applauds not only these efforts to raise the standard, but CMS recognizing the important role that providers beyond just physicians can play in helping to bring about a more uniform and quality approach to reproductive healthcare.

Specifically, CMS within the background of the proposed obstetrics provisions in the OPPS proposed rule states:

> *[W]e further propose that the organization of the obstetrical services be appropriate to the scope of services offered by the facility and integrated with other departments of the facility. For example, in order to provide high quality and safe care, a labor and delivery unit needs to ensure*

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[4] American Academy of Physician Associates. *Issue Brief: PAs in Obstetrics and Gynecology*. Jan. 2021. https://www.aapa.org/download/19515/?tmstv=1724859101.

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good communication and collaboration with services such as laboratory, surgical services, and anesthesia services as applicable. At § 482.59(a)(1) and § 485.649(a)(1), we propose that the OB patient care units (that is, labor rooms, delivery rooms, including rooms for operative delivery, and post-partum/recovery rooms whether combined or separate) be supervised by an individual with the necessary education and training, and specify that that person should be an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or osteopathy. This individual is typically responsible for a variety of activities important to patient safety, such as overseeing staff, training, overall patient care, and supporting communications within the unit and across the facility. Given the importance of the role, ensuring appropriate training and education is imperative.

The exact language in the two newly proposed sections, 482.59 and 485.649, reads:

> § 482.59 Condition of participation: Obstetrical services.
>
> [...]
>
> (1) Labor and Delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or osteopathy.

And

> § 485.649 Condition of participation: Obstetrical Services.
>
> [...]
>
> (1) Labor and Delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a Doctor of Medicine or a Doctor of Osteopathy (MD/DO).

PAs are trained and qualified to oversee and supervise obstetric services and staff. Based on the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) accreditation requirements, in addition to their medical training, all PAs are educated in patient safety, quality improvement, healthcare delivery systems, interprofessional care (including the roles and responsibilities of various healthcare professionals), and the business of medicine.[5] Additionally, 5% of the content of the

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[5] Accreditation Review Commission on Education for the Physician Assistant. *Accreditation Standards for PA Education*, 5th Edition (Sept. 2019, Effective Sept 2020). https://www.arc-pa.org/wp-content/uploads/2024/07/Standards-5th-Ed-July-2024.pdf.

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National Commission on Certification of Physician Assistants certification examination that PAs must pass as a condition of licensure includes questions related to a wide range of issues within the topic of professional practice, which is directly applicable to the proposed oversight and supervision of obstetric services and staff.[6] These same areas of knowledge and skill are also reflected in the recognized competencies for the PA profession, making PAs well-suited to supervise care, the provision of services, and interdisciplinary teams.[7] In fact, in 2022, 40% of PAs were serving as formal or informal leaders within their clinics, departments, hospitals, or health systems.[8]

AAPA urges CMS to adopt the above language regarding conditions of participation regarding obstetrical services in sections 482.59 and 485.649 of the CFR as proposed. The Academy supports these changes for their recognition of the training, education, and experience of PAs through the explicit inclusion of PAs. AAPA also supports the effort as evidenced in these specific proposed changes to raise the level and quality of reproductive healthcare in the United States.

Partial Exclusion of PAs Within Condition of Participation: Emergency Services

Emergency medicine is among the top three specialties in which PAs practice — following behind only family medicine and orthopedics. PAs in emergency medicine serve in settings from the smallest rural emergency departments (EDs) in Critical Access Hospitals to the largest Level 1 trauma centers. In rural settings, a PA may be the only provider in an ED, and in an urban trauma center they may be responsible for multi-casualty events. PAs often are the backbone of fast-track care and observation units within EDs. Employers of PAs in emergency medicine range from small hospitals to the largest emergency medicine staffing companies.[9]

Because of the prominent role of PAs within emergency medicine, it makes sense that PAs are included within the current critical access hospital provisions within section 485.618 (d) Standard: Personnel, which states:

> (1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes: […]

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[6] National Commission on Certification of Physician Assistants. *Content Blueprint for the Physician Assistant National Certifying Examination*. Jan. 2019. https://www.nccpa.net/wp-content/uploads/2020/09/PANCE-Content-Blueprint-5-21.pdf?r=1725034970. *See also:* American Academy of PAs, *Statutory and Regulatory Requirements for Initial Licensure and License Renewal*, (Jan. 2024). https://www.aapa.org/download/19739/.

[7] American Academy of Physician Associates. *Official Policy Paper: Competencies for the PA Profession*, (Adopted 2005, most recently amended 2021). https://www.aapa.org/download/90503/.

[8] American Academy of Physician Associates. *PAs in Leadership: What do they do? A report from the 2022 PA Practice Survey*. Oct. 2023. https://www.aapa.org/download/121338/?tmstv=1719505594.

[9] American Academy of PAs, *Issue Brief: PAs in Emergency Medicine*. Jan. 2021. https://www.aapa.org/download/78267/?tmstv=1725381940.

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It is within the above context of PA expertise and experience in emergency medicine and PAs already being included within personnel, that we urge CMS to amend the following language currently found in 485.618 (e), and unchanged within the proposed revisions of the OPPS (now adjusted to be in subsection f) as suggested below :

> (f) *Standard: Coordination with emergency response systems.* The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine ~~or~~, osteopathy, or physician assistant is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.

AAPA implores CMS to take the additional step of amending the proposed revisions to CoP of emergency services to include PAs within current subsection e (proposed subsection f) covering "Standard: Coordination with emergency response systems," as demonstrated above.

Telehealth

Telehealth has become an integral part of care delivery, expanding access to care and reducing patient and provider burden. The 2025 OPPS proposed rule includes multiple provisions that seek to ensure continued telehealth flexibilities, where possible, that were implemented during the COVID-19 public health emergency. AAPA provides comments on these provisions by subject.

Statutory Expirations of Telehealth Flexibilities

The COVID-19 pandemic accelerated the use and familiarity of telehealth so that it is firmly interwoven into the routine provision of care. The effect of telehealth can be seen most notably in rural or underserved areas, but its impact extends beyond such locations.

In the 2025 OPPS, CMS cautions that, because of statutory expirations, CMS is no longer authorized to extend many telehealth flexibilities. As a result of the COVID-19 pandemic, waivers and Congress had temporarily authorized flexibilities that allowed many services to be provided via telehealth with a patient's home serving as an originating site, without the need for a patient to be in a rural area. These flexibilities were extended under section 4113 of the Consolidated Appropriations Act of 2023, temporarily removing statutory restrictions on geographic location and site of service through the end of 2024. As a result, short of further Congressional intervention, as of January 1, 2025, Medicare beneficiaries receiving telehealth services will need to be in a rural area and will need to be in an approved medical facility for most services.

AAPA is aware of ongoing efforts within Congress to extend these flexibilities. AAPA favors making many of these flexibilities permanent. We urge the agency to work with Congress to resolve the issue before the end of the year. If Congress is unable to act before the end of the year, we urge CMS to explore temporary opportunities to

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mitigate the negative effects of such a sudden change by exploring their options to interpret various definitions under section 1834(m)(4) of the Social Security Act.

AAPA also recommends that CMS prepare potential educational communications regarding this issue to ensure proper billing methods beginning January 1, 2025. We note that such communications would be necessary whether Congress fails to extend any flexibilities or temporarily extends them beyond 2024. We encourage CMS to utilize a broad range of partners, including associations like AAPA, to share information of potential policy modifications that may change how health professionals provide care to their patients.

Telehealth Flexibility Extensions Within CMS Purview

While AAPA recognizes some telehealth flexibilities are beyond the purview of CMS to implement past 2024, we are pleased to see the agency has proposed extending other telehealth flexibilities where possible. AAPA encourages CMS to finalize most of their proposed extensions, as well as to identify additional opportunities to enhance flexibilities to offset the potential impending end of a large number of telehealth services.

One such telehealth extension is the proposal to continue the suspension of frequency limitations on Medicare telehealth subsequent care services in inpatient and skilled nursing facility settings and for critical care consultations through 2025. These frequency limitations, which existed before the pandemic, were reinstituted, but not yet enforced, following the end of the COVID-19 public health emergency, before being officially extended in the 2024 Physician Fee Schedule. AAPA again supports the renewed removal of these limits as CMS gathers more information as to how the pandemic has shifted practice patterns. However, we urge CMS to reconsider the temporary nature of this extension. Past commenters to CMS have identified these limitations as arbitrary and we concur there may be instances in which access to care is harmed. Removing these frequency limitations permanently would defer to health professional assessment of need and clinical judgment to determine whether in-person care is required. Consequently, AAPA recommends that CMS use the one-year extension to review relevant data regarding evolving practice patterns and, should no noticeable detriment to patient care be identified, consider permanently removing frequency limitations on select Medicare telehealth services.

Direct Supervision by Real-Time, Audio/Video Technology

In the 2025 OPPS, which in many ways mirrors the 2025 proposed physician fee schedule by design, CMS proposes to make permanent the authorization to meet direct supervision requirements using real-time, audio/visual technology for a subset of services, while extending this flexibility for other services through 2025. The OPPS proposes the extension through 2025 to apply specifically to virtual direct supervision of cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation services, and diagnostic services furnished to Hospital Outpatients. While AAPA supports CMS's efforts to make this authorization permanent in specific low-risk circumstances, we continue to oppose a broad permanent application of this authorization to all billing providers, such as PAs, due to transparency concerns.

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While AAPA recognizes CMS is attempting to provide continued flexibility to health professionals, we caution that further extension of this authorization, as it pertains to billing for PAs and nurse practitioners, puts competing priorities of CMS at risk, such as appropriate attribution of services. Consequently, while we will again not oppose a one-year extension of direct supervision via real-time, audio/visual technology for higher-risk services, we continue to advocate that this flexibility not be made permanent.

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 COVID-19 public health emergency, CMS indicated through IFC 1744[10] 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.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 public health emergency. We recognized that this flexibility was necessary to minimize exposure to COVID-19 and reduce the detrimental impacts of the pandemic on the timely provision of care. However, we were concerned about the 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 and nurse practitioners and the transparency complications that come with it. As CMS is aware, “incident to” is a Medicare billing provision that allows medical services 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 on services performed by PAs and nurse practitioners that are attributed to a physician.

Due to how services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services rendered to Medicare beneficiaries by PAs and nurse practitioners 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 provided by PAs and nurse practitioners. 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 and nurse practitioners.

One of the key elements 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) after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of

[10] The Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. https://www.cms.gov/files/document/covid-final-ifc.pdf.

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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 PA or nurse practitioner services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who did not see 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.

Care Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals and assess the professional’s overall quality of care based on a Medicare computed performance score. When services performed by PAs or nurse practitioners are hidden due to “incident to” billing, not only is Medicare unable to accurately determine PA or nurse practitioner quality scores, but these scores may not appear on the Care Compare site if the health professional does not exceed the low-volume threshold because of a limited number of services being attributed to them. PAs and nurse practitioners not being identified on Care 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 (an estimated approximately one-third of all outpatient evaluation and management services) provided by PAs and nurse practitioners attributed to physicians through “incident to” billing data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research using such data is similarly biased by a lack of attribution to the PA or nurse practitioner who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distorts 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.

The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and nurse practitioners in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and nurse practitioners was billed “incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.[11] Similarly, in CMS’s 2019 Physician Fee Schedule final rule, the agency acknowledged limitations in data usage and burden reduction estimations due to the ability to report services “incident to” billing.[12] Another concern regarding the

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[11] Medicare Payment Advisory Commission. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. https://www.medpac.gov/document-type/report/

[12] The Department of Health and Human Services. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and

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negative impact of “incident to” billing on the accuracy and validity of value-based programs was noted in a Health Affairs Blog in a January 8, 2018 posting.[13] While claims data 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 Medicare program and to an employer, can influence the analysis of PA and nurse practitioner healthcare contributions.

AAPA remains concerned that CMS continuing to authorize 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 continues to recommend that direct supervision by audio/visual communication be authorized 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 adversely affecting transparency. PAs and nurse practitioners can 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. Any further extension of direct supervision by audio/visual communication for PAs and nurse practitioners would only serve to increase costs and further impair data transparency through the potential proliferation of “incident to” billing.

AAPA urges CMS to work with Congress to extend expiring telehealth flexibilities. If Congress does not extend the expiring flexibilities before the end of 2024, AAPA requests that CMS explore options to mitigate the potential resulting effects on access by exploring flexibilities of interpretation under 834(m)(4) of the Social Security Act. AAPA also requests that CMS prepare educational communications regarding statutorily dependent telehealth flexibilities, whether Congress acts or not. AAPA commends CMS for extending telehealth flexibilities under its purview. AAPA strongly encourages CMS to not extend the authorization for direct supervision by real-time, audio/video technology for medical services performed by PAs and nurse practitioners beyond the time proposed in the rule.

Request for Update to CMS’s Use of the PA Profession Title

AAPA requests that all references to PAs in regulations and policies be listed as “Physician Assistants/Physician

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Treatment (SUPPORT) for Patients and Communities Act. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf

[13] "The Integrity of MACRA May Be Undermined By “Incident To Billing” Coding". Health Affairs Blog. January 8, 2018. DOI: 10.1377/hblog20180103.135358. https://www.healthaffairs.org/content/forefront/integrity-macra-may-undermined-incident-billing-coding

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Associates." This accurately reflects PAs who currently graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or "physician associate," but who all graduate from programs accredited by the same accrediting organization (Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (National Commission on Certification of Physician Assistants), and have the same scopes of practice. Although the profession has been known as "Physician Assistant," the official title of the profession is now recognized as "Physician Associate."[14] This is reflected in the title of the AAPA, other professional organizations[15], professional training programs[16], and state and territory laws and licensure.[17] Despite the recognized title of "Physician Associate," it is anticipated to take one or two decades for the title change from "Physician Assistant" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "Physician Assistant" and "Physician Associate" is recommended to avoid confusion.

AAPA urges CMS to properly refer to the PA profession as "physician assistants" in all official documents. We also encourage CMS to begin to reference the profession by the dual title "physician assistant/physician associate."

Thank you for the opportunity to provide comments regarding the 2025 OPPS proposed rule. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

Lisa M. Gables, CPA

Chief Executive Officer

American Academy of Physician Associates

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[14] American Academy of PAs. 2024. Title Change. https://www.aapa.org/title-change

[15] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. For example, The Academy of Physician Associates in Cardiology https://www.cardiologypa.org/; The Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org/; The Connecticut Academy of Physician Associates https://connapa.org/about-connapa/; and The Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com/.

[16] Yale School of Medicine, Physician Associate Program, https://medicine.yale.edu/pa/. Wichita State University, Physician Associate Program, https://www.wichita.edu/academics/health_professions/pa/.

[17] American Academy of PAs, Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregon-governor-tina-kotek-signs-law-changing-pa-title/. *See also*, Or. Rev. Stat. § 677. *See also,* Wis. Stat. § 448.974(1)(a)(2)-(6). *See also,* 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p).

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