American Academy of Physician Associates

June 2, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; FY 2026 Inpatient Psychiatric Facilities Prospective Payment System Rate Update

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), representing nearly 190,000 PAs (physician assistants/associates) across the United States, appreciates the opportunity to provide comments on the FY 2026 Inpatient Psychiatric Facilities (IPF) Prospective Payment System proposed rule. We write to address several critical areas where regulatory and statutory policy unnecessarily restricts the ability of PAs to provide timely, high-quality psychiatric care, particularly in underserved settings.

Mental and behavioral health, much like healthcare generally, is experiencing worsening provider shortages, compounding already existing access issues. 122 million people reside in communities with limited access to mental healthcare services.[1] As many as 65% of non-metropolitan 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.[2]

The National Center for Health Workforce Analysis projects that by 2030, 44 states will have fewer psychiatrists than required to meet the demand for services.[3] An inadequate supply of providers of behavioral and mental health services can lead to delayed diagnoses and care, resource rationing, ineffective care, and increased negative

[1] Health Resources and Services Administration, Department of Health and Human Services. *Health Workforce Shortage Areas*. January 9, 2025. https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[2] Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. *J Clin Transl Sci.* 2020;4(5):463-467. May 4 2020. doi:10.1017/cts.2020.42 https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/#r6
[3] National Center for Health Workforce Analysis, Bureau of Health Workforce, Health Resources and Services Administration, Department of Health and Human Services. *State-Level projections of supply and demand for behavioral health occupations: 2016-2030.* September 2018. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf

consequences of mental illness and substance use.[4] These issues will be exacerbated in rural and underserved areas.

To address these challenges, all qualified health professionals should be authorized to practice to the fullest extent of their education, training, experience, and license. As qualified behavioral and mental health service providers, PAs are crucial to increasing beneficiary access to essential care.

PAs are trained and qualified to treat behavioral and mental health conditions through their medical education, which includes didactic instruction and clinical practice experience in psychiatry and other medical specialties.[5] Additionally, they are nationally certified, state-licensed, and authorized to prescribe controlled and non-controlled medications. PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral and mental health services. Based on their graduate-level medical education, PAs practicing in mental health and substance use treatment can expand access to medically necessary care. PA education includes more than 2,000 hours in clinical rotations, including experience in behavioral and mental health, primary care, internal medicine, emergency medicine, and other specialties across the lifespan from pediatrics to geriatrics.[6] This training provides a foundation to address the diverse medical needs of people with mental illness or substance use issues.

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.[7] In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral and mental 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 have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to physicians.[8] PAs work to ensure the best possible care and outcomes for patients in every

[4] National Council for Mental Wellbeing. *The psychiatric shortage: Causes and solutions.* https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/. March 2018.
[5] ARC-PA. *Accreditation Standards for PA Education. Fifth Edition.* https://www.arc-pa.org/wp-content/uploads/2024/07/Standards-5th-Ed-July-2024.pdf. 2024
[6] American Academy of Physician Associates. *What is a PA?* https://www.aapa.org/what-is-a-pa/. Accessed May 20, 2025.
[7] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. *Geographic variation in the supply of selected behavioral health providers.* Am J Prev Med. 2018. https://pubmed.ncbi.nlm.nih.gov/29779543/
[8] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the health care delivery system*. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/. June 2019.

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 28% increase in PAs from 2023 to 2033.[9] This growth projection, along with PAs' qualifications, suggests an increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

As the Centers for Medicare and Medicaid Services (CMS) continues to refine policies that impact behavioral health delivery, we urge the agency to take concrete steps to modernize outdated requirements that limit PA participation in psychiatric facilities and to support legislative changes where regulatory authority alone is insufficient. These changes will help ensure Medicare beneficiaries receive comprehensive, timely, and team-based psychiatric care.

PA Certification and Recertification of Inpatient Psychiatric Services

Currently, federal regulations prohibit PAs from certifying and recertifying the need for inpatient psychiatric care under Medicare. This restriction presents a significant barrier to timely access and coordination of care, especially in rural and underserved areas where psychiatrists are in short supply.

PAs are trained and authorized to diagnose and manage behavioral and mental health conditions, including determining medical necessity for psychiatric hospitalization. They perform psychiatric evaluations, manage medications, and develop treatment plans in collaboration with psychiatrists and other clinicians. The inability to certify care they are already delivering undermines both patient access and the efficiency of psychiatric facilities. **CMS should work with Congress to amend 42 U.S.C. § 1395f and 42 CFR § 424.14 to explicitly authorize PAs to certify and recertify inpatient psychiatric services.**

Psychiatric Assessments

Section B110 of the State Operations Manual: Appendix AA outlines requirements for psychiatric evaluations in inpatient psychiatric facilities. While regulations do not prohibit PAs and other non-physician practitioners from

[9] US Bureau of Labor Statistics, US Department of Labor. *Occupational Outlook Handbook. Physician Assistants*. 2024. https://www.bls.gov/ooh/healthcare/physician-assistants.htm.

conducting these assessments, the guidance implies that such evaluations must be performed exclusively by physicians. This ambiguity has led to inconsistent interpretations across facilities and surveyors, creating confusion and sometimes causing delays in patient admission or care transitions.

This interpretation is at odds with the reality of modern psychiatric care, where evaluations are routinely performed by PAs who are trained and authorized to assess, diagnose, and treat behavioral health conditions. PAs practicing in psychiatric settings conduct comprehensive evaluations, establish diagnoses, and initiate treatment plans. They are particularly critical in rural and underserved areas where psychiatrists are scarce and timely access to care is essential to prevent worsening clinical outcomes.

When regulatory language explicitly or implicitly suggests that only a physician may perform a psychiatric assessment, it limits facility flexibility and may delay admission for patients in crisis. These delays are especially concerning given the national current strain on the behavioral health system. **CMS should revise this guidance to clarify that psychiatric assessments may be conducted by PAs.**

The Value of Social Determinants of Health (SDoH) Screening in Psychiatric Care

AAPA appreciates CMS's commitment to streamlining quality reporting and reducing unnecessary burdens on providers. We appreciate the administration's efforts to remove outdated or unnecessary reporting requirements that are overly burdensome to providers and support many of the proposed common-sense changes. However, we are concerned that the proposed removal of the *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* from the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program may unintentionally undermine patient-centered care in psychiatric settings.

SDoH screening is not ancillary to psychiatric care, but rather fundamental to understanding and addressing the complex barriers that affect treatment adherence, care continuity, and clinical outcomes. Patients with serious mental illness often face social challenges such as housing instability, food insecurity, and lack of transportation, all of which significantly impact their ability to engage in care. Without structured screening for these factors, providers are left without key information that could inform individualized care planning, reduce readmissions, and prevent avoidable emergency department utilization.

Whie CMS estimates that removing these measures would reduce the burden by approximately $814 per facility annually, we believe this marginal administrative savings is outweighed by the broader costs of uninformed care delivery. Furthermore, many psychiatric facilities have already integrated SDoH data collection into existing workflows, raising questions about the actual net burden of continuing these measures.

The proposal also appears misaligned with CMS's broader strategic direction, including its support for whole-person care models such as Comprehensive Primary Care Plus (CPC+), Behavioral Health Integration (BHI), and the Making Care Primary (MCP) model. These initiatives all recognize the importance of incorporating social risk factors into clinical decision-making and care coordination. **We respectfully urge CMS to retain the *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* in the IPFQR Program.**

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as "Physician Assistants/Physician Associates," as recognized in 20 CFR § 220.46 (a)(9).[10] 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" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of the AAPA, other professional organizations,[11] professional training programs,[12] and state and territory laws and licensure.[13] Despite the recognized title of "physician associate," it is anticipated to take some time 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 reference the profession by the dual title "physician assistant/physician associate."

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[10] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

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

[12] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: 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/, Alvernia University, Physician Associate Program https://www.alvernia.edu/academics/ug/bio-pa.

[13] 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).

Thank you for the opportunity to provide comments regarding the 2026 IPF 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, Vice President of Reimbursement and Professional Practice, at sdepalma@aapa.org.

Sincerely,

Jason Prevelige, DMSc, MBA, PA-C, DFAAPA
President and Chair of the Board
American Academy of Physician Associates