American Academy of Physician Associates

June 2, 2025

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; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the nearly 190,000 PAs (physician assistants/physician associates) throughout the United States, would like to provide comments on the 2026 Inpatient Rehabilitation Facility (IRF) Prospective Payment System proposed rule. While primarily a technical adjustment to the prospective payment system (PPS), the rule includes various policies that seek to streamline processes, decrease burden, and maximize the efficiency of care. Several outdated policies limiting the efficient provision of care persist in this setting. In the past, the Centers for Medicare and Medicaid Services (CMS) recognized these inefficiencies regarding care provision in IRFs and had proposed their removal before finalizing partial solutions. AAPA seeks to continue to work in partnership with CMS to identify and remove barriers to efficient care in IRFs, for the sake of patients, health professionals, and the Medicare program. It is within this context that we draw your attention to our comments.

Efforts to Streamline and Simplify Processes in the Proposed Rule

In the proposed rule, CMS suggests several policies to streamline processes and reduce burden. One such policy, found in a request for information, is to utilize discretion granted to the Secretary regarding timeframes of data reporting to potentially reduce the final data submission deadline for the IRF Quality Reporting Program (QRP) from 4.5 months to 45 days. This reduction, a decrease of three months from the timeline to report data, would similarly allow public reporting and feedback provided to IRFs to be released up to three months earlier (at six

months, as opposed to the current nine months). CMS suggests this reduction would allow consumers to use the most current information when making care decisions and allow any feedback to IRFs regarding quality, resource use, and other measures to be more timely and actionable.

CMS indicates that an overwhelming portion (97%) of the reported data are already submitted by IRFs within the 45-day time period. Therefore, AAPA approves of the revised timeline and more timely and actionable data for IRFs and consumers. The quicker that administrative and clinical feedback can be returned to IRFs, the sooner IRFs can use that information to improve care quality. In addition, more timely public reporting would provide more value for consumers as they make care decisions. A prompter timeline benefits the IRF, its health professionals, and its patients. However, AAPA cautions that, as the 4.5-month timeframe is currently aligned with other data submission and correction timeframes, CMS should simplify the process for those submitting data by updating all similar reporting programs to the new 45-day submission timeframe.

In the IRF PPS proposed rule, CMS makes other proposals to simplify and streamline processes. For example, CMS proposes to remove four standardized patient assessment data elements beginning with the FY 2028 IRF QRP. These four elements fall under the Social Determinants of Health (SDOH) category, including one regarding living situation, two regarding food, and one regarding utilities. The rule justifies the proposed removal, citing the potential burden of this reporting. While AAPA approves of continuous review of reporting requirements to increase efficiency and maximize the balance between useful data collection and reporting burden, we emphasize the importance of data collection surrounding SDOH, and the implications it may have regarding care efficiency.

Previous rules have defined SDOH as "socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health." In previous rules, CMS has also cited that such factors may account for as much as 50% of an individual's health.[1] Information on SDOH is often collected to improve health outcomes through recognizing and possibly remedying confounding factors. Collecting data on SDOH allows providers to identify barriers to care access and medical plan adherence that may not otherwise be identified. If providers are unaware of such barriers, medical care and subsequent care plans may be hindered with little understanding as to why. Lack of adherence to care plans may prove costly to the patient and the system, resulting in ineffective interventions or prolonged inpatient care.

SDOH seeks to enhance care efficiency by removing unforeseen mitigating factors to care. This aligns with CMS's stated objectives of the QRP, as cited in the rule, which are "improvement of care, quality, and health outcomes." While AAPA is sensitive to concerns of burdensome reporting requirements, CMS cites the burden per IRF at approximately 11 hours and $748 annually. We are concerned that prospective losses in care efficiency and

[1] Whitman, A; De Lew, N; Chappel, A; Aysola, V; Zuckerman, R; Sommers, B. 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

adverse outcomes may outweigh such minimal savings. As such, AAPA suggests reconsidering the removal of SDOH measures that could improve care delivery and health outcomes.

AAPA Recommendations to Further Maximize Efficiency of Processes in IRFs

AAPA supports CMS's general objective of identifying potential efficiencies where possible. In the proposed rule, CMS notes, "Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS." As such, AAPA requests the Secretary consider certain regulatory barriers to efficient care delivery in IRFs.

Currently, federal regulations regarding IRFs (CFR §412.622(a)) are overly physician-centric, preventing other qualified health professionals, such as PAs, from meeting patient demand. Section §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 visits, and in each subsequent week, a non-physician health professional, such as a PA, may only do one of the three visits per week. A different 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 and may impact patient treatment if a patient must 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 currently in place. Unfortunately, CMS did not choose to finalize the flexibilities as initially proposed, maintaining much of the physician-centric requirements.

AAPA requests that CMS revisit removing these inefficient barriers to care. 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 PAs provide services. CMS shows its agreement by authorizing PAs to provide one of the three weekly required visits. PAs have been demonstrated to improve access to care while providing high-quality care and patient satisfaction,

similar to physicians.[2] 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.[3] This growth projection, along with PAs' qualifications, suggests that increasing PA utilization will be an effective way to enhance care delivery efficiency. Restricting PAs to only one weekly encounter when the needs of an IRF may require more is an arbitrary restriction that may prevent patient access to high-value, underutilized rehabilitation services.

Granting an expanded authorization in this setting would not impose a requirement on IRFs, but rather give rehabilitation facilities maximum flexibility by allowing them 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. Decisions regarding which qualified health professional provides care to a patient should be made according to IRF staffing needs, and not limited by arbitrary restrictions on available care options. **Consequently, to maximize care efficiency in IRFs, AAPA reiterates its recommendation that CMS revise §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to authorize PAs to provide those services currently restricted to rehabilitation physicians.**

Future Measure Concepts

CMS is soliciting feedback in the IRF PPS proposed rule on future quality measure concepts under the IRF QRP that are most appropriate for the setting. In the rule, CMS identifies four concepts: interoperability, well-being, nutrition, and delirium.

AAPA has long recognized the importance of interoperability to improve the efficiency, quality, and functionality of patient health information and data. Effective interoperable systems can assist in care delivery, enhance the patient experience, and support care coordination for the entire healthcare team. In the past, AAPA has communicated to CMS its support for increased interoperability between systems and has advocated for the agency to provide necessary educational, financial, and logistical support to ensure widespread adoption of steps that would encourage interoperability. As such, we support CMS's ongoing and future efforts to better capture the extent of successful adoption of interoperable systems. We note the importance of system interoperability between all communicating parties, including patients (to access personal healthcare information, communicate with their health team, and to view authorizations and other communications between their care team and payers that are relevant to their personal care experience), health professionals (in communications directly with patients,

[2] 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-reportsjun19_medpac_reporttocongress_sec-pdf/. June 2019.
[3] US Bureau of Labor Statistics, US Department of Labor. Occupational Outlook Handbook. Physician Assistants. 2024. https://www.bls.gov/ooh/healthcare/physician-assistants.htm.

to transfer care information to other professionals providing care to their patients, and to receive authorizations from payers), and payers (to communicate authorizations to providers and patients alike, as well as with other payers regarding transitions and overlapping coverage). AAPA also recognizes the importance of interoperability for data collection and use. As such, AAPA supports CMS including interoperability measures in future updates to the IRF QRP to ensure system readiness and sufficient capabilities. We note that interoperability measurements exist already and recommend that CMS consult these when seeking to identify effective measures of successful implementation of interoperability.

AAPA also finds significant value in the second proposed future measure concept of patient well-being. However, we do caution that, while well-intended, it is fairly broad and may be difficult to define. We note that the examples provided of happiness, purpose, fulfillment, satisfaction, social connectedness, emotional well-being, and overall health are distinct, multi-faceted concepts that do not always have easily derived proxy measures. As such, AAPA encourages the assessment of patient well-being through validated measures.

The third future measure concept, nutrition, is a worthy aspect to try to measure as well. Doing so may encourage IRFs and their health professionals to promote, educate on, and recommend dietary adaptations (and other salutary practices such as physical activity and sleep) that may benefit patient health. However, we again caution that these factors will require multiple measures, and each would require confirmation that it is within the realm of IRFs to address and measure. We note also that nutritional requirements, quantity of needed sleep, the type of appropriate physical activity, and mitigating factors that address receptivity and success will vary by patient. Consequently, IRF success in these areas may include demonstrating the development of nutritional and preventive plans specific to each individual and demonstrating that the facility offers an environment conducive to healthy dietary and preventive practices.

Unlike interoperability, well-being, and nutrition, which are applicable to all residents in a SNF, the fourth future measure concept, delirium, while important to identify and maintain awareness regarding, would only apply to a subset of residents and thus may possibly be too specific to generalize to the IRF QRP. AAPA suggests that CMS consider whether the inclusion of delirium as a reporting measure outweighs potential additional burden to report on the condition in patients if the condition in question is not broadly applicable. We acknowledge the immediate and reverberating negative outcomes that may result from undetected delirium. As such, AAPA would alternatively support further education of IRFs and other care settings on this issue, but recommends that, should reporting burden remain a concern of CMS, this concept not be included as compulsory under the IRF QRP.

AAPA further requests that any additional items that CMS proposes to collect data regarding from health professionals be useful and actionable. We recognize the value of data in providing further information of individual and population status, assessing progress and trends, informing care plans, and encouraging behavioral changes, but similar attention must be paid to the overall burden asked of those required to report. To ensure a

proper balance, AAPA requests that CMS remain vigilant in assessing the usefulness of collected data and clearly articulate the expected benefit of each added measure.

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).[4] 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,[5] professional training programs,[6] and state and territory laws and licensure.[7] 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 where 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."

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

[5] 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.

[6] 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.

[7] 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 IRF PPS 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 & Professional Practice, at sdepalma@aapa.org.

Sincerely,

Jason Prevelige, DMSc, MBA, PA-C, DFAAPA
President and Chair, Board of Directors