



September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Medicare Program; CY 2018 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1678-P)

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 115,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicare Program; CY 2018 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems proposed rule.

PAs practice medicine, are authorized to prescribe in all 50 states and the District of Columbia and support the team approach to care. PAs deliver primary and specialty care to Medicare patients and play an essential role in improving the health of Medicare beneficiaries. It is within that context we provide our comments.

Supervision of Hospital Outpatient Therapeutic Services

CMS proposes to temporarily not enforce the direct supervision requirement for outpatient therapeutic services in critical access hospitals (CAHs) and small rural hospitals having 100 or fewer beds for calendar years 2018 and 2019. CAHs and small rural hospitals have challenges in recruiting and retaining PAs, physicians and other qualified providers and there is a need to ensure patient access to medically necessary services. Access to certain therapeutic services will be limited if the direct supervision requirement is not removed. AAPA agrees that all Medicare beneficiaries have the right to the same level of quality and safe outpatient care, but as CMS has noted, there are no known quality care issues or beneficiary complaints when outpatient hospital therapeutic services are performed with general supervision as compared to direct supervision.

AAPA is not aware of quality concerns during the previous CMS rule that temporarily eliminated the direct supervision requirement. With this in mind, CMS should strongly consider a permanent elimination of the direct supervision requirement in CAHs and rural hospitals having 100 or fewer beds.

AAPA fully supports the proposal to eliminate the direct supervision requirement for outpatient therapeutic services in CAHs and small rural hospitals having 100 or fewer beds for calendar years 2018 and 2019. We appreciate CMS’ recognition and understanding of the unique needs and challenges of delivering care in rural and underserved communities and believe that this proposed policy change will increase access to care for Medicare beneficiaries.

Hospital Outpatient Quality Reporting Program

In the proposal, CMS suggests removing the quality measure, “OP–21: Median Time to Pain Management for Long Bone Fracture” for the CY 2020 payment determination and the CY 2021 payment determination and subsequent years. CMS acknowledges that OP-21 has the potential to lead to negative unintended consequences by creating undue pressure for hospital staff to excessively prescribe opioids. AAPA recognizes the importance of reducing incentives for the over-prescribing of opioids and instead encourages measures that incentivize a decrease in unnecessary opioid use.

AAPA supports the removal of quality measure, “OP–21: Median Time to Pain Management for Long Bone Fracture” to mitigate the opioid crisis in the United States.

Potential Revisions to the Laboratory Date of Service Policy

CMS is soliciting public comments on billing for molecular pathology tests and advanced diagnostic laboratory tests (ADLTs) ordered less than 14 days after a hospital outpatient discharge. CMS is considering modifying § 414.510(b)(5), which currently has provisions for a test ordered “by the patient’s physician.” AAPA encourages CMS to modify this provision to include tests ordered “by a patient’s physician or PA.” PA training and scope of practice includes medical assessment and the determination and ordering of diagnostic tests. This modification would ensure coverage of medically necessary tests when ordered by a patient’s PA.

AAPA encourages CMS to modify § 414.510(b)(5) to include coverage of molecular pathology tests and advanced diagnostic laboratory tests ordered by PA.

Reducing Unnecessary Burdens

The Medicare program authorizes PAs to deliver medical services that would otherwise be provided by physicians. PAs are committed to providing the highest quality care for all Medicare beneficiaries. To accomplish that goal it is essential that Medicare’s policies authorize PAs to practice to the top of their education and training. In addition, the program should eliminate any rules or regulations that obstruct the ability of patients to receive medically necessary care from PAs due to outdated policies that don’t improve care quality or cost-effective care delivery.

In this document we have provided examples of Medicare policies that:

Disrupt continuity of care for patients: the inability of PAs, who might have been treating a patient for 15 years, to certify, order and deliver hospice care, and to certify and order home health services;

Hinder the Medicare program’s transition toward value-based care delivery models by promoting the collection of poor data: lack of accurate data on PA-provided care, lack of direct payment to PAs and the inability for patients to join accountable care organizations if all of the patient’s care is received from a PA or NP;

Increase administrative burdens without improving quality: requiring physician co-signatures on medical records after a patient has been treated by a PA and released from the hospital, and requiring a physician co-signature days after a PA has examined a patient and determined that they should be admitted to the hospital; lack of consistency in the application of Medicare coverage policies by state Medicare Administrative Contractors;

Reduce patient access to care especially in rural and underserved communities: the inability of PAs to supervise cardiac and pulmonary rehabilitation programs, order diabetic shoes, and order medical nutritional therapy services.

The following are statutory and regulatory burdens with proposed solutions:

1. Description: PAs are the only health profession not authorized to receive direct reimbursement from the Medicare program.

Summary:

PAs are the only health professionals authorized to bill Medicare for their services who can't receive direct reimbursement for those services. This barrier limits the flexibility of PAs to work in new and evolving practice and care models, and does not allow PAs to assign their reimbursement to other entities in the same manner as physicians, advanced practice nurses and other healthcare professionals such as physical therapists, anesthesiologist assistants, registered dietitians, occupational therapists, etc.

Related Statute/Regulation: [42 CFR §1395u\(b\)\(6\)\(C\)](#)

Proposed Solution: Change statutory language to authorize PAs to receive direct payment from Medicare.

2. Description: Ensure that transparency exists for services delivered by PAs in the transition to value-based care delivery.

Summary:

One of the key components of the shift to value-based care delivery is the collection and analysis of accurate and actionable data dealing with quality, outcomes, resource allocation, and other factors. Due to Medicare's current claims processing system, the care provided by PAs is often attributed to physicians (i.e. "incident to"). PAs are essentially "hidden providers" when this occurs. This means that any payment system that seeks to assess quality and outcomes for health professionals such as PAs and NPs, and reimburse accordingly, is likely to be fundamentally flawed.

Related Statute/Regulation: "Incident to" billing requirement listed in [the Medicare Benefit Policy Manual, Chapter 15 - Section 60.2](#)

Proposed Solution: CMS should mandate that the name of the health professional who actually rendered patient care be listed and trackable in the Medicare claims system.

3. Description: PAs and NPs are not recognized by Medicare for purposes of certifying the need for, and ordering, diabetic shoes.

Summary:

PAs are already authorized to order durable medical equipment. The exclusion of diabetic shoes is a rare exception to this authority. PAs commonly manage the care of diabetic patients. Medicare, however, requires a physician to certify the need for diabetic shoes and requires a physician to order diabetic shoes. These Medicare requirements result in additional physician visits of a PA's diabetic patient, who is in need of diabetic shoes, so that a physician can fulfill Medicare's requirements for the certification and order. Authorizing PAs to certify and order diabetic shoes will improve access to care and eliminate unnecessary physician visits, certifications and orders.

Related Statute/Regulation: [§1861\(s\)\(12\) of the Social Security Act](#)

Proposed Solution: Change the statute to authorize PAs and NPs to certify the need for, and order, diabetic shoes. AAPA supports H.R. 1617, the Promoting Access to Diabetic Shoes Act, by Reps. Tom Reed (R-NY) and Earl Blumenauer (D-OR) that would remove this barrier for PAs and NPs.

4. Description: PAs are not recognized by the Medicare program for purposes of ordering home health and signing the home health plan of care.

Summary:

PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs (and NPs) for purposes of certifying or ordering home health services or signing the home health plan of care for these same patients. This inability to certify or order home health for Medicare patients leads to a lack of continuity of care for Medicare beneficiaries, especially in rural and underserved communities, because the patient's primary care provider, the PA, is unable to order medically necessary services for the patient. The inability to sign the plan of care results in the inability of PAs to write orders (i.e. writing prescriptions and ordering durable medical equipment) related to caring for their patient. Ensuring patients have the right level of care at the appropriate time often prevents an escalation in the patient's condition and the need for more acute and expensive healthcare services. Certifying the need for home health services is clearly within a PA's education, training and state law scope of practice.

Related Statute/Regulation: 42 USC [§1395f\(a\)](#), [§1395n\(a\)](#), [§1395x\(m\)](#), [§1395x\(o\)\(2\)](#), [§1395fff](#)

Proposed Solution: Change statutory language to allow PAs to certify, order and sign the plan of care for home health services. AAPA supports H.R. 1825, the Home Health Care Planning Improvement Act of 2017, introduced by Reps. Chris Collins (R-NY) and Jan Schakowsky (D-IL) that would remove this barrier for PAs and NPs.

5. Description: PAs are not recognized by Medicare for certifying a terminal illness, ordering hospice and functioning as an "attending physician" under the Medicare hospice program.

Summary:

PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs for certifying terminal illness, ordering hospice, and providing and managing (acting as an “attending physician”) hospice services. This lack of PA recognition leads to a disruption in continuity of care for beneficiaries, especially in rural and underserved communities, because the patient’s primary care provider, the PA, is unable to order medically necessary services for the patient. A patient is often most vulnerable when dealing with a terminal illness. It is especially unfair for a patient to lose the ability to work with, and be treated by, their primary medical provider during this uniquely difficult time. In addition, having a patient avoid a stay in an acute care setting as they are dealing with their hospice related condition will save the system money.

Related Statute/Regulation: [42 USC §1395x\(dd\)\(3\)\(B\)](#), [1395f\(a\)\(7\)](#)

Proposed Solution: Change statutory language to allow PAs to certify a terminal illness, order hospice and serve as an “attending physician”. Partial fix would be achieved with passage of H.R. 1284, the Medicare Patient Access to Hospice Act, by Reps. Lynn Jenkins (R-KS) and Mike Thompson (D-CA) that would remove the barrier of PAs not being allowed to serve as an “attending physician.”

6. Description: PAs are required to obtain a physician co-signature on hospital admission orders prior to a patient’s discharge.

Summary:

Medicare policy permits PAs to write the admission order and perform a history and physical (H&P) to determine the necessity of an inpatient hospital admission. However, any such orders must be co-signed by a physician, potentially days later, prior to a patient’s discharge from the facility. Requiring a physician to take the time to co-sign an admission order, after the PA’s determination of medical necessity has already been deemed sufficient, is an inefficient use of a physician’s time. If a physician is not available the patient’s discharge may be delayed resulting in an increased length of stay in the hospital.

Related Statute/Regulation: [CMS Transmittal 234](#)

Proposed Solution: CMS should clarify that when a PA orders a hospital admission a physician is not required to co-sign the admission order.

7. Description: PAs are required to obtain a physician co-authentication (co-signature) on hospital (inpatient and outpatient) discharge summaries.

Summary:

When a PA discharges a patient from the hospital, a physician’s co-signature is required on the discharge summary within 30 days of the patient’s discharge. This must be done for all hospital inpatient and observation stays, emergency department services, and hospital outpatient department services. Requiring that all discharge summaries be co-signed by a physician is an enormous administrative burden for facilities and an inefficient use of a physician’s time. There is no clear value

being provided to the patient or the healthcare system from this requirement.

Related Statute/Regulation: CMS [State Operations Manual, Appendix A, Section 482.24\(c\)\(4\)\(vii\)](#)

Proposed Solution: CMS should modify regulatory language to remove the requirement for physician co-authentication of a discharge summary.

8. Description: The lack of consistency in the application of national Medicare coverage and reimbursement policies by state Medicare Administrative Contractors creates confusion in the ability for health professionals and health systems to follow Medicare policy.

Summary:

Medicare Administrative Contractors (MACs) are contracted to implement national Medicare policy at regional levels. However, ambiguous Medicare regulations have led MACs to vary in their interpretations of certain national Medicare policies, and thus have resulted in different policy implementations by different MACs. Consequently, equivalent health professionals are currently subject to varying rules rooted in the same statute or regulations, based on divergent MAC interpretations.

Related Statute/Regulation: Medicare requirements for Shared Visit billing can be found in the [Medicare Claims Processing Manual, Chapter 12, 30.6.1.B](#)

Proposed Solution: CMS should identify and actively respond to reports of discrepancies between Medicare Administrative Contractor interpretations of national Medicare policies and correct any ambiguous language in order to foster more uniform implementation of CMS coverage policy.

9. Description: PAs are not recognized by Medicare for purposes of supervising cardiac, intensive cardiac, and pulmonary rehabilitation programs.

Summary:

Studies have shown that Medicare patient outcomes are improved when they have access to cardiac and/or pulmonary rehabilitation services. Currently, only physicians are authorized to supervise Medicare beneficiaries for cardiac and/or pulmonary rehabilitation services. When a physician is not available, the beneficiary does not have access to these important services. Supervising these services (establishing an exercise program, counseling, education, outcomes assessment, etc.) is within the scope of practice and level of expertise of appropriately trained PAs.

Related Statute/Regulation: [§1861\(eee\) of the Social Security Act](#)

Proposed Solution: Change the statute to allow PAs to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs. AAPA supports H.R. 1155, bipartisan legislation by Reps. Lynn Jenkins (R-KS) and John Lewis (D-GA) that would resolve this barrier.

10. Description: PAs are not recognized by Medicare as being able to supervise other health personnel who perform diagnostic tests.

Summary:

PAs are authorized to request and perform diagnostic tests consistent with their state law scope of practice. However, only a physician may supervise the performance of these tests by ancillary staff. PAs are highly qualified, by training and education, in the performance of diagnostic tests, as well as in emergency services that may be required during testing. Authorizing PAs to supervise diagnostic tests will improve efficiency in the healthcare system by and expanding access to care.

Related Statute/Regulation: [Program Memorandum Carriers, Transmittal B-01-28, Change Request 850](#), April 19, 2001; and [42 CFR §410.32\(b\)](#)

Proposed Solution: CMS policy should authorize PAs to supervise diagnostic tests within their state law scope of practice when performed by other office technicians/certified personal.

11. Description: Medicare requires that PAs in certified rural health clinics (RHCs) provide certain diagnostic services, but does not create a method for the PA to be reimbursed for these mandated services.

Summary:

Federally certified RHCs must have a PA, nurse practitioner or certified nurse midwife staff the clinic 50 percent of the time the clinic is open. Medicare requires RHCs to offer specific diagnostic tests to be performed in RHCs. Unlike the payment methodology for the typical RHC patient visits, these diagnostic services require billing and reimbursement through Medicare Part B. Medicare does not allow direct payment to PAs through Part B. Therefore, PA RHC owners are not paid for these required services and that lack of payment could threaten the financial viability of the RHC. PAs are essential healthcare providers in RHCs and Medicare should provide a means to assure payment to PA RHC owners for required Part B services.

Related Statute/Regulation: [42 CFR 491.9](#)

Proposed Solution: CMS should require that a payment method be established when PAs in RHCs are performing CMS-mandated diagnostic tests to beneficiaries (such as authorizing Medicare to provide direct payment to PAs – see #1 priority).

12. Description: Medicare patients being treated solely by a PA or an NP cannot be included in an accountable care organization (ACO) unless they have at least one visit with a physician.

Summary:

ACOs are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. PAs are listed by Medicare as one of three types of health professionals who deliver primary care services. However, only patients who have had at least one visit by a physician are eligible to be assigned/attributed to an ACO. Medicare beneficiaries treated solely by PAs and NPs can't be assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA is the only health professional in the community.

Related Statute/Regulation: [42 CFR §425.402\(a\)](#)

Proposed Solution: Change the statute to allow patient attribution to an ACO when the patient has received all of their medical care solely from a PA or an NP. AAPA supports H.R. 1160, the ACO Assignment Improvement Act of 2017, introduced by Reps. Derek Kilmer (D-WA) and Lynn Jenkins (R-KS) that would remove this barrier.

13. Description: PAs are not authorized to participate in or lead the interdisciplinary team for the Programs for All-Inclusive Care for the Elderly (PACE) program.

Summary:

CMS issued a proposal that would authorize PAs (and NPs) to be members of interdisciplinary teams as part of the Programs for All-Inclusive Care for the Elderly (PACE) thereby reducing administrative burdens and increasing patient access to care. However, the overarching final rule has been held up for regulatory review.

Related Statute/Regulation: [Programs of All-Inclusive Care for the Elderly \(PACE\) Manual - Chapter 8 – IDT, Assessment & Care Planning - Section 10.1.](#)

Proposed Solution: Change the statute to authorize PAs to participate in and lead the interdisciplinary team for the PACE program. *Note: CMS has proposed to authorize PAs be able to provide services within the PACE program in a proposed rule (File Code-CMS-3295-P; Medicare and Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care). The final rule has not been released so it is unclear how the final rule would come out on this issue or if the rule will be released.*

[Language to include PAs is contained in proposed rule CMS 4168-P](#)

14. Description: Medicare uses the confusing term “licensed independent practitioner” when referring to those health professionals who are authorized to order restraint and seclusion in hospitals. This confusion can cause PAs not to be able to order restraint and seclusion.

Summary:

CMS issued language as part of a proposed rule that would remove confusing language in Medicare regulations that designates health professionals as licensed independent practitioners (LIP). CMS proposed to eliminate this term and replace it with the term “licensed practitioners” which would allow PAs to practice in accordance with their state license, thus reducing administrative burdens and increasing patient access to care. However, the overarching final rule has been held up in regulatory review.

Related Statute/Regulation: [Hospital Conditions of Participation \(CoP\);](#)

Proposed Solution: CMS should eliminate the term "licensed independent practitioner" and use "licensed practitioner" or refer to the specific health professional being discussed to avoid confusion. *Note: CMS has proposed to eliminate LIP language in a proposed rule (File Code-CMS-3295-P; Medicare and Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and*

Improvement in Patient Care). The final rule has not been released and it is unclear how the final rule would come out on this issue or if the rule will be released.

[language to eliminate LIP language is contained in proposed rule CMS 3295-P](#)

15. Description: PAs are limited by regulation and interpretation from providing certain inpatient hospital psychiatric services.

Summary:

PAs provide psychiatric services to Medicare patients in outpatient settings, consistent with state law scope of practice. Inpatient psychiatric services, however, are highly restricted, as patients are required to be under a physician’s supervision and progress notes must be recorded by an MD/DO. These restrictions create delays and inefficiencies in the care and treatment of inpatient psychiatric patients. Authorizing PAs to provide and document care to patients in psychiatric hospitals would improve access to care for these patients.

Related Statute/Regulation: [Medicare Benefit Policy Manual Chapter 2 – Inpatient Psychiatric Hospital Services](#); Sections 30.2.1.1 and 30.2.1.2 restricts PA certification/recertification

Proposed Solution: Remove regulatory restrictions regarding services PAs may perform and document in psychiatric hospitals.

16. Description: PAs are not recognized by Medicare as being able to order medical nutritional therapy (MNT).

Summary:

PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. Currently, however, only physicians are authorized to order MNT service. This physician-only requirement results in administrative burden and delay in care for patients in need of these services, as patients must wait for a physician order. Authorizing PAs to order these services will improve care for patients while reducing administrative burdens and inefficiencies.

Related Statute/Regulation: [42 CFR § 410.132](#)

Proposed Solution: Change the statute to authorize PAs to order MNT. Language in the Social Security Act reads as follows: (vv)(1) The term “medical nutrition therapy services” means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)). We suggest adding “or a PA (as defined in subsection (aa)(5))” after (r)(1).

17. Description: PAs are not recognized by the Medicare program for purposes of interpreting the results of a screening mammography.

Summary:

The Social Security Act limits the interpretation of results of a screening mammography to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type “that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO)” including the ordering, performing, and interpreting of diagnostic tests. A delay in interpretation can cause unnecessary stress to a patient and potentially delay referral to an appropriate provider if results are abnormal. Delay in care could also affect healthcare efficiency, increase cost of care, and result in health complications.

Related Statute/Regulation: [§1861\(jj\) of the Social Security Act](#)

Proposed Solution: Change the statute to authorize PAs to interpret the results of a screening mammography. Language in the Social Security Act reads as follows: “(jj) The term “screening mammography” means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician’s interpretation of the results of the procedure.” We suggest adding “or PA’s” after the word physician.

18. Description: PAs are not recognized by the Medicare program for purposes of interpreting bone mass measurement results.

Summary: The Social Security Act limits the interpretation and reimbursement of bone mass measurement to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type “that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO)” including the ordering, performing, and interpreting of diagnostic tests. Without timely interpretation, appropriate care to Medicare beneficiaries may be delayed. Delayed treatment of osteopenia/osteoporosis and initiation of fall prevention behaviors could result in falls and fractures, increased hospitalizations, avoidable procedures, increased health care costs, and disability.

Related Statute/Regulation: [§1861\(rr\)\(1\) of the Social Security Act](#)

Proposed Solution: Change the statute to authorize PAs to interpret bone mass measurement results. Language in the Social Security Act reads as follows: “(2) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician’s interpretation of the results of the procedure.” We suggest adding “or PA’s” after the word physician.

19. Description: PAs are not recognized by Medicare for purposes of performing the comprehensive visit, and the required alternating physician mandatory visits, in skilled nursing facilities (SNFs).

Summary:

For many years, PAs have been authorized to deliver care to Medicare beneficiaries in SNFs. However, PAs are not recognized by Medicare regulation for purposes of performing the comprehensive visit to SNF patients. Also, PAs and physicians are required to alternate every other required visit to SNF patients. There is no reason and no medical evidence that would support such restrictions on PAs (and NPs) from performing the comprehensive SNF visit and each required visit. This Medicare requirement

is simply a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system.

Related Statute/Regulation: Memorandum Ref: [S&C: 13-15-NH](#)

Proposed Solution: CMS should remove regulatory restrictions and authorize PAs to perform the comprehensive visit, as well as to perform all required visits, in SNFs.

Conclusion

PAs are responsible for providing millions of patient visits each year and are an essential part of the healthcare delivery system. PAs must be able to practice with as few regulatory barriers as necessary in order to provide efficient, cost-effective care. AAPA appreciates the agency's consideration of our comments and looks forward to a continued working relationship with CMS to ensure the best possible care for all Medicare beneficiaries. If you have any questions about our comments or concerns please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy at 571-319-4345 or michael@aapa.org.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Gail Curtis". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

L. Gail Curtis, MPAS, PA-C, DFAAPA
President and Chair of the Board