



November 19, 2018

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

Re: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 123,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on reducing unnecessary Medicare and Medicaid regulatory and administrative burdens that drive up costs and impede Medicare beneficiaries from receiving the care they need. Our comments focus on regulatory burdens and the solutions CMS can implement to bring about a significant positive impact on improving care delivery for patients.

Regulatory Modifications to the Medicare Program

Transparency Concerns Resulting from “Incident To” Billing

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 and nurse practitioners (NPs) is often attributed to physicians through “incident to” billing. PAs and NPs are essentially “hidden providers” when this occurs. This affects PAs and NPs by “hiding” relevant data that may influence their ability to participate in the Quality Payment Program or how they’re displayed on Physician Compare. This also impacts the ability of employers to assess the quality of care and contribution of their providers, encumbers patients through confusing explanations of benefits and a lack of complete information to make informed care-delivery choices, and impedes the Medicare program by predicating their analysis and policy decisions on issues such as network adequacy on erroneous attribution data.

Proposed Change: CMS should mandate the name of the health professional who actually rendered patient care be listed and trackable in the Medicare claims system. This can be accomplished without eliminating the “incident to” billing provision.

Performing Hospital Admissions

Medicare policy permits PAs to write the admission order and perform a history and physical 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. We note that recently-finalized changes to documentation of hospital admission under the Hospital Inpatient Prospective Payment System may correct this problem, however, CMS has yet to explicitly clarify that a physician co-signature is not required when a PA admits a patient to the hospital.

Proposed Change: CMS should clarify that when a PA orders a hospital admission, no physician co-signature is required.

Licensed Independent Practitioner Terminology

Medicare policy uses the confusing term "licensed independent practitioner" when referring to those health professionals who are authorized to order restraint and seclusion in hospitals. This terminology is often used to deny the ability of PAs to order restraint and seclusion. In 2015 CMS proposed to eliminate this term and replace it with "licensed practitioner," which would allow PAs to practice in accordance with their state law. However, the overarching final rule which would have contained this updated language was never released.

Proposed Change: CMS should continue to work toward elimination of the term "licensed independent practitioner" and use "licensed practitioner" or refer to the specific health professional being discussed to avoid confusion.

MAC Consistency

Medicare Administrative Contractors (MACs) are contracted to implement national Medicare policy at the state level. However, some MACs have created local policies that are not in alignment with national Medicare policies. Consequently, health professionals are subject to Medicare practice variability based on divergent MAC interpretations. Additional administrative burdens are created when large health systems that have practice locations across multiple states are forced to implement different Medicare regulatory requirements based on individual MAC policies instead of being able to apply a consistent set of rules in similar practice settings.

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

Restrictions on PA Practice in Skilled Nursing Facilities

For many years, PAs have been authorized to deliver care to Medicare beneficiaries in skilled nursing facilities (SNFs). However, PAs are not recognized by Medicare regulation for the 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 supports 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.

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

Restrictions on Home Health Services

PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not authorize PAs (and NPs) to certify patient eligibility for home health services, order home health services, or sign the home health plan of care for these same patients. These restrictions lead to a lack of continuity of care for Medicare beneficiaries, especially in rural and underserved communities. Although PAs are permitted to conduct the required face-to-face visit to determine eligibility, that same PA, who might be the patient's primary care provider, is not permitted to actually make the certification and 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 and ordering home health services are clearly within a PA's education, training and state law scope of practice.

Proposed Change: CMS should utilize discretionary flexibilities granted to the Secretary to make modifications that would allow PAs to certify eligibility for, order and sign the plan of care for home health services.

Ensuring Best Practices in the Medicaid Program

Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, each state can determine the various boundaries of practice of health professionals such as PAs and NPs under the Medicaid program. Some states currently include restrictive language regarding PA practice that impedes efficient provision of care, including restrictions on PAs acting as an assistant at surgery, the ordering of DME, and providing psychiatric care and substance abuse treatment. Further, there are policies adopted by some states that restrict the transparent delivery of care, including requiring that claims for services provided by PAs be billed under and attributed to the collaborating physician, not reimbursing for professional services provided by hospital-employed PAs and the omission of PAs from provider directories.

Proposed Change: AAPA recommends CMS release a series of best practices for state Medicaid program policies regarding PAs emphasizing burden reduction and transparency, and promoting that PAs be permitted to practice to full extent of their education, competency and training.

Thank you for the opportunity to provide feedback on the efficiency and burden reduction proposed rule. AAPA welcomes further discussion with CMS regarding our position and comments. For any questions you may have in regard to our comments and recommendations, 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 "Jonathan E. Sobel". The signature is fluid and cursive, with a large initial "J" and "S".

Jonathan E. Sobel, DMSc, MBA, PA-C, DFAAPA, FAPACVS
President and Chair of the Board