June 15, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Centers for Medicare and Medicaid Services (CMS)

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021 CMS-1737-P

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 140,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the 2021 Inpatient Rehabilitation Facility Prospective Payment System proposed rule. As a result of COVID-19, increased flexibilities are being authorized by CMS in order to maximize the efficiency of, and access to, high quality medical care. AAPA supports these regulatory flexibilities that allow health professionals to practice to the full extent of their education, clinical competence, and experience in order to meet care needs, and it is within this context that we draw your attention to our comments.

Currently, Code of Federal Regulations (CFR) 412.622(a) regarding Inpatient Rehabilitation Facilities (IRFs) allows only a physician to provide certain rehabilitation services. For example, §412.622(a)(3)(iv) indicates a rehabilitation physician must 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. A different section, CFR §412.622(a)(4)(ii), requires a rehabilitation physician to conduct a post-admission evaluation within 24 hours of admission, and document that evaluation in the patient's medical record.

To address concerns of regulatory burdens in IRFs, promote competition and ensure an adequate healthcare work force for IRFs, 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' proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place.

PAs have the appropriate training

CMS asks whether quality of care will be affected by this proposal. PAs practice medicine and are authorized to prescribe in all 50 states and the District of Columbia, and virtually every public (Medicare, Medicaid, Tricare) and commercial third-party payer in the country covers services provided by PAs. PAs provide healthcare to patients on a quality and safety level comparable to physicians, confirmed both by data and research studies and borne out of a rigorous education and training in the medical model.

The typical student entering a PA educational program has a bachelor's degree and over three years of previous healthcare experience. PA program applicants must complete at least two years of college courses in basic science and behavioral science prior to entering a PA program. This is analogous to pre-med studies required of medical students.

PAs are educated at the graduate level at one of 254 PA programs that are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).[1] These programs consist of classroom (didactic instruction and lab instruction), and clinical rotations. Accreditation Standards require that clinical rotations must be in the following settings: outpatient, emergency department, inpatient, and the operating room. Programs are 27 months in duration and include approximately 2,000 hours of clinical rotations.[2]

This educational preparation equates to an average program length of seven semesters or three academic years. Elective rotations are available and include additional time in core rotations or subspecialty experiences.

According to ARC-PA Standard B2.06, curriculum must include instruction in the provision of clinical medical care across the life span that prepares PAs to provide preventive, emergent, acute, chronic, rehabilitative, palliative and end-of-life care.[3] Curriculums include content relevant to adolescent, adult, and elderly populations. These rotations give students intensive inter-professional experiences in managing the needs of patients across the life span in a variety of common settings. Students commonly rotate through nursing homes, rehabilitation facilities and hospitals.

Once PAs graduate from an accredited program they are eligible to take the Physician Assistant National Certifying Examination (PANCE) to receive national certification from the National Commission on Certification of Physician Assistants (NCCPA), an independent certifying body. All states require PAs to pass the national certifying examination as a condition for licensure. Initial certification conferred by the NCCPA verifies that a practitioner has demonstrated an appropriate level of medical knowledge across the spectrum of medical conditions and practice settings.

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[1] http://www.arc-pa.org/accreditation/accredited-programs/

[2] http://paeaonline.org/wp-content/uploads/2017/06/Program-Survey-31_V4_Updated-June-2017.pdf

[3] http://www.arc-pa.org/wp-content/uploads/2016/10/Standards-4th-Ed-March-2016.pdf

IRF patients will continue to receive high-quality care

Numerous studies show the quality of care PAs provide is comparable to that of physicians in terms of patient safety, outcomes, and mortality.[4,5,6] Studies also demonstrate no significant difference in adverse events, hospital lengths of stay, readmissions, or transfers to intensive care with PAs compared to physicians providing inpatient care.[7,8,9,10,11,12] In addition, PAs perform procedures with similar safety, outcomes and accuracy as physicians.[13,14]

Patient satisfaction with care provided by PAs is also extremely high, with patients indicating not only that they are trustworthy, but also that PAs provide excellent services.[15,16] Nearly a quarter of all people surveyed in one study preferred to see a PA over a physician, with a plurality of respondents aged 18-34 preferring PAs.[17] Further, studies demonstrate PAs often care for the same patient medical complexity as physicians.[18]

Conclusion

We commend the agency for officially proposing to 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. We note that this proposed change does not impose a requirement on IRFs, but instead gives rehabilitation facilities maximum flexibility by providing them with the option to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation work force that provides patients with timely access to care. Each IRF will continue to be able to determine which health professionals have the necessary education, training and experience to meet the care needs of their patients.

Thank you for your review of the information AAPA submitted in support of this policy change. We appreciate your commitment to removing unnecessary practice barriers and expanding access to needed rehabilitation services. AAPA encourages CMS to finalize these proposed policies.

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[4] Yang Y, et al, (2018) https://pubmed.ncbi.nlm.nih.gov/28893514/
[5] Faza NN, et al (2018) https://pubmed.ncbi.nlm.nih.gov/29957606/
[6] Auerbach DI (2018) https://pubmed.ncbi.nlm.nih.gov/29924944/
[7] Althausen PL, et al (2016) https://pubmed.ncbi.nlm.nih.gov/27870674/
[8] Capstack TM, et al (2016) https://www.mdedge.com/jcomjournal/article/146081/practice-management/comparison-conventional-and-expanded-physician
[9] Dies N, et al (2016) https://pubmed.ncbi.nlm.nih.gov/26818645/
[10] Agarawal A, et al (2016) https://pubmed.ncbi.nlm.nih.gov/26910566/
[11] Nabagiez JP, et al (2016) https://pubmed.ncbi.nlm.nih.gov/27234575/
[12] Rymer JA, et al (2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6201421/
[13] Enriquez-Marulanda A, et al (2018) https://pubmed.ncbi.nlm.nih.gov/29949011/
[14] Raza S (2018) https://insights.ovid.com/circulation-cardiovascular-quality-outcomes/cicq/2018/04/001/abstract-15/15/01337496
[15] Strzelczyk TA, et al (2017) https://pubmed.ncbi.nlm.nih.gov/29759676/
[16] Lindelow J, et al (2018) https://www.auajournals.org/doi/10.1016/j.juro.2018.02.776
[17] Dill, et al., (2013) http://dx.doi.org/10.1377/hlthaff.2012.1150
[18] Ellen T. Kurtzman et al., 2017 https://www.aapa.org/download/21803/

AAPA welcomes further discussion with CMS regarding this issue. For any questions you may have please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319- 4345 or michael@aapa.org.

Sincerely,

David E. Mittman, PA, DFAAPA
President and Chair of the Board