July 7, 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 and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

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 second COVID-19 Public Health Emergency (PHE) interim final rule, the Regulatory Revisions in Response to the COVID-19 PHE. In response to the COVID-19 pandemic, CMS has authorized numerous regulatory changes and flexibilities in order to increase patient access to care and protect both patients and healthcare professionals. Some of these regulatory relief measures are identified as temporary, lasting only through the duration of the public health emergency (PHE). However, as the COVID-19 crisis accentuates the importance of America's healthcare work force being able to practice to the full extent of their education and experience, we are pleased that several of the policies increasing PA practice flexibility are now permanent.

CMS made significant progress in its first COVID-19 interim final rule by identifying a number of telehealth flexibilities that support safer care delivery, temporarily authorizing PAs to certify home health services under Medicaid (later made permanent by Congress), and clarifying the ability of PAs to document their patient findings in psychiatric hospital progress notes. AAPA appreciates CMS' recognition of the need for these flexibilities, as well as those flexibilities extended in this second interim final rule.

The Regulatory Revisions in Response to the COVID-19 PHE (the second interim final rule) makes significant additional strides in removing regulatory barriers to care.

Home Health and Durable Medical Equipment (DME)

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27, built on the first COVID-19 PHE rule and provided a legislative requirement authorizing PAs to certify home health and establish/review the plan of care for Medicare beneficiaries, and required the Medicaid program to implement home health policies that mirror Medicare. The CARES Act gave CMS six months to officially implement the legislation.

Language contained in the Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule provides for immediate implementation of those home health policy changes established in the CARES Act for PAs with a retroactive effective date of March 1, 2020.

Prior to the release of the Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule, many state Medicaid agencies restricted PAs and APRNs from ordering Durable Medical Equipment (DME) for Medicaid beneficiaries because there is no stand-alone federal Medicaid language authorizing PAs or APRNs to order DME. Rather, the only mention of DME in federal Medicaid regulations exists under the section on home health, which led some states to interpret that the restrictive nature of home health policies also pertained to DME. The Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule's explicit reference to the Medicaid program of the ability of PAs and APRNs to certify home health largely rectifies this restriction from the perspective of CMS.

AAPA welcomes this change to home health policy under both the Medicare and Medicaid programs. We request that CMS encourage states to expeditiously modify any existing state law or Medicaid language that perpetuates Medicare or Medicaid restrictions on PAs under home health. AAPA also requests that CMS conduct a broad review of home health language in the Code of Federal Regulations (CFR) that requires updating in light of CMS' authorization of PAs and APRNs to perform home health duties. Some examples in which physician-centric language stand in contrast to these policy changes can be found at 42 CFR§ 409.43, 42 CFR§ 409.64, 42 CFR §410.170, 42 CFR 484.50, 42 CFR 484.55, and 42 CFR 484.110. Confusion will exist if existing CMS references to home health do not remove physician-centric language and specify the authorization of PAs and APRNs to certify home health and establish/review the plan of care for Medicare beneficiaries.

AAPA is similarly concerned regarding unclear language in 42 CFR §424.22(a)(1)(v)(A)(4). We have already heard from stakeholders who falsely interpret the section to indicate that only independent PAs may certify. AAPA suggests that CMS rewrite 42 CFR §424.22(a)(1)(v)(A) with simplified language to instead convey the message that the face-to-face encounter should be performed by the certifying physician or certifying allowed practitioner, or else a physician or allowed practitioner from the acute or post-acute care facility from which the patient was directly admitted. Unnecessary mentions of supervision and collaboration only stand to further complicate this point when relationship requirements for such professionals are spelled out elsewhere in the CFR.

AAPA also wishes to identify one other potential point of confusion with 42 CFR §424.22(a)(1)(v) in section (C). This provision, which requires the face-to-face at the home health facility to be performed by the physician or allowed practitioner who is certifying need for home health, may run into complications if a state has regulatory language that permits a face-to-face to be performed by a non-physician practitioner, but not certification. A requirement by CMS that both of these services be performed by the same individual may then unintentionally prohibit non-physician health professionals from providing either service. AAPA requests that CMS provide an exemption for such scenarios until state law is able to be modified and make an explicit request of states to modify any restrictive language that may work in opposition with CMS' intentions for flexibility.

We urge CMS to revise the category II Healthcare Common Procedure Coding System (HCPCS) codes G0179, G0180 and G0181 currently utilized for home health services. The descriptors for these codes use physician-centric language, "physician re-certification," "physician certification" and "physician supervision," respectively, and need to be changed to become provider neutral.

Finally, home health form CMS-485, while not required, is often used to certify home health. The form uses the term "Attending Physician" in signature box 27. We ask the agency to update this form to be provider neutral to eliminate any confusion about the ability of PAs and APRNs to provide home health services to beneficiaries.

Ensuring Continued Access to Care After the Public Health Emergency

AAPA has identified other policies in which CMS has provided temporary flexibility that should be made permanent.

Supervision of Diagnostic Tests

PAs are authorized to request and perform diagnostic tests consistent with their state law scope of practice. However, only a physician may supervise ancillary staff performing these tests. As a result of the Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule, PAs are now authorized to supervise technicians and other trained personnel who assist in the performance of diagnostic tests.

However, this flexibility allowing PAs to provide required supervision of personnel performing diagnostic tests is only recognized for the duration of the PHE. AAPA finds no reason this flexibility should expire with the conclusion of the PHE and requests that CMS use its regulatory authority to make this a permanent change. PAs are highly qualified by training and education to perform diagnostic tests. Authorizing PAs to supervise diagnostic tests will improve efficiency in the healthcare system by expanding access to care.

Skilled Nursing Facilities

AAPA believes the need for increased flexibilities, efficiencies and more robust utilization of all health professionals will not lessen when the PHE ends. In addition to our comments on making diagnostic test supervision regulatory relief permanent, AAPA notes another temporary flexibility, authorized in the first interim final rule, that, if made permanent, would produce significant benefit to patients. The issue deals with the removal of unnecessary requirements as to who may provide services in skilled nursing facilities (SNFs). During the PHE, CMS authorized the delegation of "physician-only" tasks in SNFs to PAs, if there is no conflict with state law or facility policy. AAPA sees little justification for re-instituting these arbitrary practice restrictions after the PHE ends. PAs are clinically prepared and competent to deliver this care. Patient access to care is improved, especially in rural and underserved communities, when PAs are able to provide these services.

Additional Regulatory Relief Needed

CMS has demonstrated through recent policy changes a willingness and ability to adapt policies to meet the changing dynamics in our healthcare delivery system. This regulatory flexibility benefits patients by reducing access burdens and ensuring health professionals are available to deliver timely care. With this in mind, AAPA requests CMS consider addressing other regulatory barriers which hinder efficient practice. One such barrier is confusion over the authorization of PAs to sign a patient's hospital admission order, without the need for a physician co-signature, when the order and admission history and physical are personally performed by a PA. Another example of regulatory burdens placed on PAs involves the Medicare hospice program, including the restriction on PAs ordering medications for hospice patients if the PA is employed by a hospice organization, as well as the inability for a hospice-employed PA to be chosen to serve as an attending physician for a patient, if an attending physician had not been selected by the patient upon election of the hospice benefit.

Thank you again for your efforts to reduce the regulatory burdens placed on PAs which hinder our ability to provide efficient, coordinated care to patients. AAPA welcomes further discussion with CMS regarding these issues. For any questions you may have please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at michael@aapa.org.

Sincerely,

Beth R. Smolko, DMSc, PA-C
President and Chair of the Board