



September 17, 2021

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753 -P
7500 Security Boulevard
Baltimore, MD 21244-1850

Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 151,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Center for Medicare and Medicaid Services' (CMS) proposed 2022 Payment Policies Under the Hospital Outpatient Prospective Payment System (OPPS). PAs are committed to increasing access to high quality care for all Medicare beneficiaries and we seek to work in partnership with CMS in the advancement of healthcare policies that help in achieving that goal. PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies made in the Hospital OPPS proposed rule. PAs will have an increasingly important role in the US healthcare delivery system and currently provide hundreds of million patient visits each year. Many of those visits are from Medicare beneficiaries. It is within this context that we draw your attention to our comments.

Changes to Coinsurance for Certain Colorectal Cancer

Medicare currently pays for colorectal cancer screening procedures, including screening flexible sigmoidoscopies and colonoscopies, and beneficiaries are not required to pay Part B coinsurance for these screening tests. However, if a polyp or lesion is detected and biopsied or removed, the procedure is no longer considered a screening test and becomes a diagnostic test, for which beneficiaries are responsible for the usual 20 or 25 percent coinsurance, depending on the site of service, that applies to service. Although this created dissatisfaction for patients, health professionals, and other stakeholders, Federal statute did not allow for elimination of the coinsurance.

In 2021, legislative language in Section 122 of the Consolidated Appropriations Act (CAA) stated that for services furnished on or after January 1, 2022, a flexible sigmoidoscopy or a colonoscopy can be considered a screening flexible sigmoidoscopy or a screening colonoscopy test even if an additional procedure is furnished to remove tissue or other matter during the screening test. Furthermore, the CAA policy change progressively decreases the percentage amount of coinsurance for which a beneficiary is responsible over a period of years, ultimately resulting in zero coinsurance on or after January 1, 2030.

In the 2022 Hospital OPPS proposed rule, CMS is proposing to codify in regulations the amendments made in the CAA that flexible sigmoidoscopy or colonoscopy screening tests that require a related procedure, including removal of tissue or other matter, furnished in connection with, because of, or during the same clinical encounter as the screening test, will be considered a colorectal cancer screening test. In addition, the coinsurance required of Medicare beneficiaries for colorectal cancer screening tests that result in additional procedures furnished in the same clinical encounter will be reduced from 20 or 25 percent to 0 percent from 2022 through 2030.

AAPA appreciates CMS aligning Medicare regulations with amendments made by section 122 of the CAA. AAPA and the PA profession support health promotion, disease prevention, and increased access to cost-effective care. To further achieve these aims, CMS should increase access to colorectal cancer screening procedures by authorizing PAs to perform colonoscopies and eliminate current [policy](#) that payment for colonoscopies only be made when performed by a doctor of medicine or osteopathy. No such limitation on the type of provider is included in the [Social Security Act](#) and PAs have demonstrated the competency to perform colonoscopies, including biopsies when medically necessary, comparable to gastroenterologists in technical performance and quality metrics. Specifically, a [study](#) demonstrated that there were no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies, and that “this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies”.

The phased elimination of coinsurance for colonoscopies will likely lead to increased demand for trained and competent endoscopists. In addition, it has been [estimated](#) that the American Cancer Society’s new recommendation to initiate screening colonoscopies at age 45 rather than 50 years will increase demand for colonoscopies 22% and add 21 million people to the current pool of 94 million eligible persons. The lowering and eventual removal of patient coinsurance along with an increased demand from patients eligible for the procedure will place a serious strain on the availability of colonoscopy services. The increased demand for colonoscopies will likely have a disproportionately negative impact on rural populations obtaining access to this important preventive service. This lack of access would be counterproductive to CMS’ goal of increased health equity.

As there is no statutory exclusion to PAs performing colonoscopies and the utilization of trained PAs performing colonoscopies has been demonstrated to provide high quality care and outcomes, AAPA recommends that CMS authorize payment for screening colonoscopies, including colonoscopy screening tests that require removal of tissue or other matter, when those services are performed by PAs.

Rural Emergency Hospitals RFI

Closures of rural hospitals and critical access hospitals (CAHs) are leading to a lack of services for people living in rural communities. In response, Section 125 of the CAA established a new healthcare facility-type called Rural Emergency Hospitals (REHs) where services may be provided effective January 1, 2023.

Provisions in the CAA authorize the Secretary of Health and Human Services to determine what, if any, additional health and safety requirements, beyond certain mandatory requirements, should apply to REHs.

AAPA supports REHs and the increased access to care they will provide. As noted by CMS, about [20%](#) of the US population lives in a rural area and [one in five](#) of these residents identifies as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or a combination of ethnic backgrounds. People in rural areas have been [shown](#) to have shorter life expectancy, higher all-cause mortality, increased adverse social determinants of health, and reduced access to healthcare providers.

To gain the full benefits of increased patient access to care and health equity through REHs, AAPA encourages CMS to authorize PAs to provide all services in REHs consistent with State law and facility policy - - without additional regulatory requirements (i.e., direct physician supervision, physician co-signatures, etc.). Any additional regulatory or administrative requirements limit access to, and efficiency of, available healthcare professionals without providing any demonstrable benefit. For example, [regulations](#) that require a physician to review and sign records of “all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants” at CAHs is administratively burdensome, inefficient, and has no proven benefit on care quality or outcomes. Placing such a requirement on REHs would be counterproductive to the very intent of the program. **AAPA encourages CMS to avoid imposing unnecessary clinical, regulatory, or administrative barriers to PAs providing care in REHs and asks that the agency review and modify existing outdated regulations at CAHs and other facilities that limit the ability of PAs to provide medically necessary care.**

Solicitation on Temporary Policies to Address the COVID-19 PHE

Care in Skilled Nursing Facilities

During the current PHE, CMS authorized the delegation of “physician-only” visits in SNFs to PAs and nurse practitioners, if not precluded by state law or facility policy. This decision was based on the need to increase access to care while understanding that the flexibility would not adversely affect the quality of beneficiary care or the integrity of the Medicare program. During the nearly two years that this flexibility has been in place, there has been no reported adverse consequences related to the policy change. To the contrary, SNFs have been able to use the flexibility to provide high-quality care to SNF residents during a pandemic. There is no clinical justification for re-instituting this outdated policy when experience has demonstrated the high-quality care PAs deliver. PAs are clinically prepared, educated, and competent to deliver the full range of needed clinical care in SNFs/NFs. When PAs are authorized to deliver care to the full extent of their education and state law scope of practice, patient access to care is improved, especially in rural and underserved communities.

AAPA also encourages CMS to permanently eliminate policy that mandates that certain visits in a skilled nursing facility (SNF) or nursing facility (NF) be furnished only by a physician and allow all required and services in SNFs and NFs to be performed by a PA.

Care in Hospitals

During the COVID-19 Public Health Emergency (PHE), CMS issued many coverage and payment policy waivers and flexibilities to improve access and increase the efficiency of healthcare delivery. CMS is now

seeking comment on whether certain temporary policy flexibilities permitted during the PHE should be made permanent, to the extent possible.

AAPA is committed to the delivery of quality healthcare and working with the agency to reduce administrative burdens that hinder patient access to care. We appreciate the PHE flexibilities permitted by CMS and believe many should be made permanent.

One such flexibility that should be made permanent is the ability for inpatient Medicare beneficiaries to be under the care of a PA. CMS waived requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) that require Medicare patients be under the care of a physician. PAs provide care in teams with physicians and other healthcare professionals, and there is nothing in statute or in the medical evidence that would preclude a hospitalized patient from being “under the care of” a PA. Authorizing patients to be under the care of a PA would eliminate outdated regulations that make delivering care less efficient. For example, the requirement that every Medicare beneficiary be “under the care of a doctor” in a hospital has led to an interpretation that when an authorized health professional other than a physician writes an order for admission, a physician must co-sign it. Medicare policy permits PAs to determine the necessity of an inpatient hospital admission, write the admission order, and perform the accompanying history and physical examination. Despite this, the CMS requirement for a patient to be “under the care of a physician” and the additional unnecessary requirement of a physician co-signature, potentially days after a PA’s determination of medical necessity, is an inefficient use of a physician’s time and does not lead to higher quality care for beneficiaries. Furthermore, if a physician is not available, the patient’s discharge from the hospital may be delayed, resulting in an increased length of stay in the hospital and increased cost to the Medicare or Medicaid programs.

Authorizing a patient to be “under the care of” a PA would provide the same collaborative and coordinated care as has been traditionally provided without imposing arbitrary administrative burdens. As previously mentioned, and despite what some stakeholders may assert, there is no known difference in quality or outcomes when modern, collaborative care is “under the care of” a physician or a PA. In fact, a 2019 [report](#) by the Medicare Payment Advisory Commission concluded that “a large body of research, including both randomized clinical trials and retrospective studies”, demonstrates that care provided by PAs “produces health outcomes that are equivalent to physician-provided care.” In addition, there are facility safeguards to ensure that quality care is delivered to beneficiaries, regardless of whether a patient is under the overall care of a PA or physician. For example, value-based payment and public reporting measures, facility by-laws and privileging requirements and other measures will ensure that high-quality and safe care is provided.

Therefore, AAPA encourages CMS to change to 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) and authorize Medicare patients in the inpatient setting to be under the care of a PA.

Digital Quality Measurement

In the 2022 Hospital OPPI proposed rule, CMS includes a request for information on its efforts to transition fully to Digital Quality Measurement for its quality programs. CMS is requesting input on the transition to Digital Quality Measurement for planning purposes and anticipates specific requirements regarding data submission standards will be released in future rulemaking.

In the proposed rule, CMS defines a Digital Quality Measure as “a software that processes digital data to produce a measure score or measure scores.” Digital Quality Measures use health information that can be captured and transmitted across interoperable systems and from various data sources, such as electronic

health records (EHRs), medical devices, claims data, case management systems, patient portals, wearables, and more. The aggregation of this data from multiple sources, CMS claims, will provide a more holistic perspective of a patient's well-being and the type of care received by reducing data fragmentation. AAPA approves of the ability to extract data from more sources, however, there must be assurance that there are standards for accuracy and usability of new data sources.

The transition to Digital Quality Measurement relies not only interoperability but also increased standardization of data. CMS is proposing to collect all clinical EHR data required for quality measures via Fast Healthcare Interoperability Resources (FHIR)-based application program interfaces (APIs), allowing drastically different software used at different care locations to communicate and submit data in a similar manner. FHIR is a standards framework that seeks to unify measure structure and reporting by establishing a common language and process for all health information technology. CMS expects the FHIR framework to provide consistency as it seeks to align standards across federal and state agencies, as well as private commercial payers. AAPA approves of CMS aspirations to increase standardization of measures and processes across public and private payers. Such consistency would simplify the process and reduce reporting burden on healthcare professionals, as well as allow for greater comparability across programs.

The proposed rule identifies Digital Quality Measurement as a bridge to a learning health system that utilizes standards-based data sharing and analysis, provides rapid-cycle feedback, and aligns quality measurement with incentives to continuously improve care. CMS hopes the change will streamline data collection by automating much of the analysis and reporting. CMS also expects patients will benefit from expected improved quality of care and reduced costs.

AAPA concurs with CMS' goals of an increase in relevant data sources, reduced complexity in quality measurement, and enhanced ease of data submission. AAPA agrees that health professionals, such as PAs, would benefit from increased standardization and interoperability. If collection of data for reporting can be incorporated as an automated background system process occurring during a health professional's course of providing care, extraction and analysis of this data would not have to be a separate time-intensive process that could be prone to human error. We also see value in CMS' promise of rapid feedback through access to near real-time quality measure scores, as it would allow for prompt adjustments to be made to practice patterns and processes. Increased ease of data transmission may also benefit health professionals by supporting their ability to enhance care coordination, and support more precise clinical decisions.

However, AAPA would like to draw CMS' attention to certain considerations the agency should keep in mind when developing or modifying measure requirements. The three concerns listed below are essential for CMS to address if it is committed to enhancing the holistic nature of data collection, promoting increased coordination of care, increasing the integrity of data, and ensuring increased usefulness of feedback on quality.

First, health information technology that will collect data for Digital Quality Measurement must be accessible and useable by all health professionals who provide medical care to patients. CMS should require that certified electronic health record technology (CEHRT) have full functionality for all health professionals that deliver medical care, including PAs and NPs. If health professionals, such as PAs, are prevented from fully accessing and utilizing CEHRT systems, data collected will be imprecise.

Second, any newly established or modified measures should not be phrased in a way that might exclude health professionals. Capturing the contribution of health professionals, like PAs and NPs,

through appropriately worded measures will allow CMS' to reach its goal of enhanced comparability of care quality.

Third, digital measures and the corresponding feedback must be accurately attributed to the health professional who rendered the service. This will maximize the relevance of data capture and analysis by ensuring that feedback used to adjust and improve clinical practice be returned to the professional who actually delivered the care. To do this, AAPA requests that CMS address the complications of inaccurate data collection brought about by the “incident to” billing method, which attributes services personally performed by PAs and NPs to a physician.

CMS believes that advances in technology and policy requirements implemented over the past several years, which have led to increased interoperability and applied data standards, support the transition to Digital Quality Measurement. The agency's goal is to complete this transition to Digital Quality Measurement within its quality and value-based programs by 2025, moved up from an earlier stated goal of 2030. However, CMS noted the possibility that requirements and timelines for full transition to Digital Quality Measures may vary by quality reporting program. Whenever the transition occurs, the agency should ensure there is sufficient time to meet required technical milestones and provide sufficient widespread instruction on new requirements to affected stakeholders. **We recommend that CMS, in addition to soliciting feedback on the details of the implementation, also consult various stakeholders on the feasibility of designated timelines.** CMS must be sure that interoperability is a well-established standard at the point of implementation or assessments of quality will continue to be incomplete due to missing/unavailable data points. AAPA cautions that there may be entities that cannot financially or logistically make necessary transitions. Educational and other assistance may be necessary to improve the capacity for such entities to meet Digital Quality Measurement requirements and standards.

Direct Supervision

Direct supervision is the level of supervision Medicare requires for “incident to” billing, some diagnostic tests, and certain other services. During the public health emergency, CMS indicated through IFC 1744¹ that direct supervision requirements could be met by the supervising clinician being available via audio/visual (interactive) communication. This flexibility was granted to minimize the transmission of COVID-19, meet the increased needs of patients, facilitate the utilization of telehealth, and mitigate the risk of patients not receiving timely medical care.

In the 2022 Hospital Outpatient Prospective Payment System proposed rule, CMS is seeking input on whether the ability to use audio/visual communication to meet the requirements of direct supervision should be made permanent for all services for which direct supervision is required, whether the flexibility could be made permanent for only some services, or, if authorization for virtual direct supervision should be allowed to expire, what the timeline for sunseting the flexibility should be.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 Public Health Emergency. We recognized that this flexibility was necessary to minimize exposure to COVID-19 and reduce detrimental impacts of the pandemic on the timely provision of care. While we had formerly requested that the agency make this provision permanent, AAPA is no longer in support of a blanket use of audio/visual communication to meet direct supervision

¹ <https://www.cms.gov/files/document/covid-final-ifc.pdf>

requirements. Our concern is due to the negative effects that will result related to transparency. As noted in our previous comments, despite requesting permanent authorization of audio/visual communication to meet direct payment requirements, we were concerned regarding the impact on transparency. These concerns remain and now incline us to recommend that CMS only authorize audio/visual direct supervision in certain circumstances.

AAPA continues to have significant concerns regarding “incident to” billing for services provided by PAs/APRNs and the transparency complications that come with it. As you are aware, “incident to” is a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to us is “incident to” billing pertaining to services performed by PAs and APRNs that are attributed to a physician. Due to the manner services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services delivered to Medicare beneficiaries by PAs and APRNs may be attributed to physicians. When this occurs, it is nearly impossible to accurately identify the type, volume or quality of medical services delivered by PAs and APRNs. Accurate data collection and appropriate analysis of workforce utilization is lost. This lack of transparency has a negative impact on patients, health policy researchers, the Medicare program, and PAs/APRNs.

One of the key issues in ensuring that healthcare is consumer-centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB) notice after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of the visit. “Incident to” billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the MSN/EOB notice. When PA services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who was not seen by the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Physician Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals with an assessment of the professional’s overall quality of care based on a Medicare computed performance score. When services performed by PAs are hidden due to “incident to” billing, not only is Medicare unable to determine PA quality scores, but these scores may not appear on the Physician Compare site if the health professional does not exceed the low-volume threshold as a result of fewer services attributed to them. In addition, if PAs have all their services billed under “incident to,” those PAs may not appear on the Physician Compare website. PAs not being identified on Physician Compare, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a healthcare provider.

With a substantial number of services provided by PAs and APRNs attributed to physicians in “incident to” billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research performed using such data are similarly biased by a lack of attribution to the PA or APRN who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distort the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies. Under “incident to” billing, claims data collected and used by the Medicare

program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care and resource use allocation.

The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and APRNs in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and APRNs was billed “incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.² Similarly, in CMS’ recent 2019 Physician Fee Schedule final rule, the agency acknowledged that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services “incident to” a physician when furnished by a PA or NP.³ The absence of data attributed to PAs and APRNs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program, and threatens their ability to be listed along with other health professionals on performance measure websites, such as Physician Compare. Similar concern regarding the negative impact of “incident to” billing on the accuracy and validity of value-based programs has been echoed in a Health Affairs Blog in a January 8, 2018, posting.⁴ While claims reimbursement is by no means the only measure of a health professional’s value and productivity, it is an essential component. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, can influence the analysis of PA/APRN healthcare contributions.

AAPA is concerned that CMS authorizing a blanket fulfillment of direct supervision requirements by audio/visual communication would only make it easier to use “incident to” billing, thereby leading to expanded use of the billing mechanism. This would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional.

Consequently, due to our ongoing concerns with “incident to” billing and its harm to transparency, AAPA instead suggests that direct supervision by audio/visual communication be extended beyond the end of the public health emergency only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for these health professionals, such as registered nurses, medical assistants, and technicians, will find benefit in expanded patient access to care as it will increase flexibility in supervisory requirements for such professionals to perform their duties. However, no such benefit exists for health professionals such as PAs and APRNs. PAs and APRNs are able to provide services, under their own names instead of a physician’s name, and at a lower cost of care/reimbursement rate. An extension of direct supervision by audio/visual communication for PAs and APRNs would only serve to further impair data transparency through the potential proliferation of “incident to” billing.

² http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

³ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>

⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20180103.135358/full/>

Disparities and Equity

CMS' Request for Information (RFI) on the topic of reducing disparities and promoting health equity, contained within the 2022 Hospital Outpatient Prospective Payment System Proposed Rule, makes clear that these goals are a priority for the Biden Administration. This is further confirmed through the inclusion of this RFI in various other proposed rules. As a first step, the proposed rule solicits ideas on how best to collect data on demographics and health inequities.

AAPA supports the goals of addressing disparities and promoting equity in healthcare. We agree with CMS' desire for increased specificity of data to address disparities and inequities as a logical first step. We encourage CMS to not confine its focus on ensuring robust data solely to demographic data, as other reforms in the ways in which data is collected may also support reductions in disparities. For example, the elimination of "incident to" billing would also lead to data specificity that would have a direct link to determinations of health equity. The increase in accurate attribution of services to the health professional who provided the care would help provide a clear depiction of which health professionals are providing quality care, and which are not.

In addition to AAPA's support for CMS' appeal for more data, we believe there is more CMS can do to minimize health disparities and promote health equities, and that PAs can play an integral role in CMS' efforts. AAPA would like to draw CMS' attention to two sources of health disparities: 1) disparities caused by policies that restrict access to needed services, and 2) disparities caused by policies that promote the inefficient provision of care. It is our belief that policy changes, which AAPA has identified below, will better enable PAs to contribute to a more equitable delivery of care to patients.

Disparities in Care Resulting from Disparities in Access

Our healthcare system contains many barriers to access that affect beneficiaries unevenly, resulting in disparities. For example, both long wait times in high population areas with an insufficient number of providers, and a shortage of health professionals in a rural setting may delay access to care to the point that may be detrimental to patient health. Patients in these situations who are inhibited by financial constraints, health conditions, and transportation limitations have few options to gain access to care in a timely fashion and may be required to endure long wait times or forgo care altogether. This can create a discrepancy between the level of care received in these settings and in locations where care is easier to access.

PAs can help ease these access limitations. The US health system faces a clinician shortage, particularly in primary care, that is being exacerbated by an aging population.⁵ As a result, PAs and APRNs are currently providing a substantial portion of the high-quality, cost-effective care that our communities require, and will continue to do so to meet the needs of their communities. As of 2017, there were more than 260,000 PAs and APRNs billing for Medicare services. According to the Medicare Payment Advisory Commission (MedPAC) approximately half of all Medicare patients receive billable services from a PA or APRN.⁶ As noted by

⁵ Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4: https://aspe.cms.gov/system/files/pdf/167396/NP_SOP.pdf

⁶ MedPAC June 2019 Report to Congress, page 151:

http://medpac.gov/docs/defaultsource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

MedPAC, the number of Medicare beneficiaries being treated by PAs and APRNs continues to grow. However, if PAs and APRNs continue to face policy constraints that prohibit them from providing care they are qualified to provide, then CMS is unnecessarily constraining a powerful resource in its arsenal in addressing access disparities.

One example of an archaic policy that unnecessarily limits PAs and consequently the ability of patients to access essential services is the unnecessary requirements for physicians to provide certain services in skilled nursing facilities (SNFs). During the current public health emergency, CMS authorized the delegation of “physician-only” visits in SNFs to PAs, if there is no conflict with state law or facility policy. AAPA sees no clinical justification for re-instituting these outdated practice restrictions when years of experience has demonstrated the high-quality care PAs deliver in SNFs. Other examples of antiquated policies that limit access include the requirement that a physician be physically present for sufficient periods of time in a Critical Access Hospital to provide medical direction/consultation/supervision for services provided, and the requirement for a physician to perform a certain number of visits in Inpatient Rehabilitation Facilities. Each of these requirements necessitate physician involvement that may not be readily available in rural settings, or available in a timely fashion in high-demand settings. PAs are clinically prepared, educated, and competent to deliver the full range of needed clinical care in these settings. CMS demonstrated an agreement with this position when it authorized PAs to provide such services in SNFs during the public health emergency. Patient access to care is improved, especially in rural and underserved communities, when PAs are authorized to deliver care in these settings to the full extent of their state law scope of practice.

In certain instances, patients are unable to access care most appropriate to their healthcare needs and desires. In such instances, patients should be able to transfer to another care setting with minimal difficulty. However, in emergency situations, if a patient requires a transfer and a physician is present, the physician must sign off on the transfer. If a physician is not present, a PA may sign off on the transfer, but only if they have first consulted a physician and subsequently receive a physician countersignature on the order. AAPA finds such requirements antiquated and inefficient. PAs can authorize a transfer in nonemergency situations and should be authorized to in emergency situations. Requiring a physician signature may result in frequent pulling of a physician from other patients. When a physician is not present, the requirement for physician consultation on any such transfers, especially in areas with a deficiency in the number of physicians available, may prolong the transfer process to a facility more equipped to meet a patient’s immediate needs, thereby delaying access and potentially endangering the patient’s health. The requirement for countersignature is then superfluous as the determination to transfer a patient has already occurred.

Disparities in Care Resulting from Policies that Perpetuate Inefficient Care Delivery

Certain Medicare policies, some regulatory and some legislative, impede the efficient delivery of care. Use of the “incident to” billing provision requires those health professionals who choose to use it to meet a series of requirements to be in proper compliance. Some of these requirements, such as the requirements for a physician to see the patient on the initial visit and for a physician to be within the suite of offices, create an increased burden that compromises optimal efficiency of care for patients seen under this arrangement. In addition, depending on one’s geographic location, a Medicare Administrative Contractor may require additional documentation to meet “incident to” qualifications, creating an even more inefficient process for some based on the region of the country care is being provided. Due to the inefficiencies brought about by

the numerous requirements for “incident to,” in addition to transparency concerns already noted, this billing mechanism should be eliminated.

Similarly, other restrictive policies may prohibit PAs from helping some patients get a service in a timelier fashion. Examples of such restrictive policies include the prohibition of PAs from certifying terminal illness and admitting to hospice, the exclusion of PAs from being able to conduct the face-to-face evaluation prior to recertification under hospice, the inability to order therapeutic shoes without physician involvement, the lack of authorization for PAs to order Medical Nutrition Therapy, and the barring of PAs from interpreting screening mammography. When PAs are unable to provide these services, patients must wait for other health professionals, who may not be available, or available in a timely manner, to do so.

These CMS policies exacerbate disparities in care by creating situational discrepancies in access and inconsistencies in the efficiency or quality of care received. **AAPA requests that CMS review the policies identified here to determine what changes it can make to reduce inequities stemming from the agency’s regulatory prohibitions.**

Thank you for the opportunity to provide feedback on the 2022 Hospital Outpatient Prospective Payment System Proposed Rule. 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,



Jennifer M. Orozco, MMS, PA-C, DFAAPA
AAPA President and Chair, Board of Directors