January 7, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the approximately 150,000 PAs (physician assistants) throughout the United States is aware of the Biden Administration's review of payment models with the objective of addressing disparities and promoting equity in healthcare. CMS has further confirmed its commitment to focusing on reducing disparities through the agency's Request for Information (RFI) included in the 2022 Physician Fee Schedule, 2022 Hospital Outpatient Prospective Payment System, and other proposed rules. As a first step, the RFI 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, both for the Centers for Medicare and Medicaid Innovation (CMMI), as well as for the Centers for Medicare and Medicaid Services (CMS) generally. 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, working with Congress for the elimination of "incident to" billing or increasing transparency to identify the health professional who actually delivered care 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 PAs from providing needed services to patients, and 2) disparities caused by policies that result in 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.[1] 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.[2] As noted by 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. Such requirements are 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

[1] 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
[2] MedPAC June 2019 Report to Congress, page 151: http://medpac.gov/docs/defaultsource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

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 above to determine what changes it can make to reduce inequities stemming from the agency's regulatory prohibitions.**

AAPA would welcome a meeting with representatives of both CMS and CMMI to discuss these issues further. PAs wish to help contribute to a reduction in health disparities and promote health equity. 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,

Lisa M. Gables, CPA
Chief Executive Officer