GRPA COMMISSION REPORT TO THE BOARD OF DIRECTORS
June 2020

Name of Commission: *Government Relations & Practice Advancement (GRPA)*

Commission Chair: *Dan Forsberg*

Commission Members: *Kevin Bolan*
Rebekah Lee
Kevin Hickman
Brendan Lucas
Nichole Bateman
William Reynolds (board representative)
Jennifer Orozco (board representative)
Tillie Fowler (staff advisor)

Executive Summary:

The Commission was tasked with reviewing several resolutions for the 2020 House of Delegates (HOD). We deliberated over many conference calls and individual exchanges to come to agreement and consensus on the best policies to bring to the AAPA HOD and facilitate moving our profession forward. Cooperative efforts with other constituent organizations was particularly robust and lead to consensus on items touching a diversity of topics.

Many of the GRPA calls included updates and input from AAPA's reimbursement team and state/federal teams. We feel this collaboration is invaluable to commission members as most discussions impact practicing PA's directly and the profession as a whole. We also had presentations from other AAPA staff to educate the commission on communications activities and grassroots outreach and how it intersects with the work of the commission.

Detailed Progress Report:

Commission Charge	Status
Advise AAPA staff on the impact of new healthcare models and value-based healthcare delivery on PAs and serve as a resource on PA payment policy.	• Update on AMA Roll Out of E/M Documentation Guidelines for Office-Based Services. No longer will the emphasis be on history and examination; it will be focused more on medical decision making and what takes up the most time while with a patient — comorbidities, risk factors, how hard it is to get information out of a patient, etc. Want to make sure everyone in the healthcare community is on board. AAPA and others are worried if a provider is given the ability to do less history, and there is less

	that needs to be entered into the record, what effect will that have down the road? • Discussion with a commission member and reimbursement staff about Medicaid regulations scheduled to start Nov. 1. Staff thinks referring to the PECOS system, which is reaching its deadline in terms of enrollment. This led to an offline discussion between them.
Identify current and/or emerging barriers to practice and discuss options to eliminate the barriers.	• Discussed AAPA comments to CMS, as a result of the administration's Patients over Paperwork campaign, that provided information on PA scope of practice so they can understand the barriers for PAs and what policy changes might be needed to open up things for them and for Medicare patients. In addition, inform commission about AAPA spearheaded letter from COs to CMS. • Discussed MedPAC meetings and conversations related to transparency and their report recommendation to eliminate incident-to. Shared with the commission a sign-on letter AAPA created to increase the conversation about incident-to. It says to CMS that whether or not incident-to is eliminated, there still needs to be a conversation about how services by PAs are hidden. • Update on meeting with CMS on several issues. Discussed inaccuracy of CMS data because it captures PA contributions under the physician's name, the elimination of incident to, other solutions to transparency problem among others. • Update on meeting with CMS on hospice to reduce confusion around PAs providing hospice care. The rule allows PAs to provide care; but some within CMS think there is another provision that says PAs cannot prescribe medications to hospice patients, which pretty much negates the point of PAs providing care. • Update on final rule that finally removed Licensed Independent Provider language by removing the word "independent," and

	made some changes in the psychiatric arena regarding psychiatric hospital records. • Update on President's executive order that directs the Secretary of HHS to eliminate burdens, including supervision requirements that are more stringent than state laws. It also calls to examine reimbursement disparities between physicians and other providers. • Update on final physician fee schedule which included a big victory by Medicare allowing a new definition of what it means to have supervision from a physician. AAPA has been talking with them for more than a year, telling them states are changing how they address that relationship, and that Medicare wasn't in tune, that they needed to shift. Medicare says they will defer to state law as to what the working relationship needs to be. Caveat: in the absence of any language, they would want something additional at the practice level to describe what the working relationship is. This should allow OTP to move forward without the concern that states might not be aligned with Medicare. The issue of preceptorship also addressed. Now say PA students will be treated exactly the same way as medical students, and that PAs can be preceptors. And the final rule clarifies that PAs may prescribe hospice, the same as a physician. There is still work to do here. HHS and CMS now really seem to understand the role of PAs and are willing to push back against physicians when they complain. It made it unnecessary to seek a fix through Congress.
Provide feedback and advice on OTP implementation. Encourage legislators to support related bills at state and federal levels.	• Provided updates throughout the year on status of OTP bills in states. • Requested commission advice on materials and strategies to move needle in the states. • Discussed the Direct Pay Bill in congress. • Update on the PA-important provisions included in the 2020 physician fee schedule. Most importantly, this regulation changes the terminology around supervision to defer to state law. AAPA is trying to emulate the

	NP language that is currently in place with Medicare.
Review, provide practice examples and assist in getting stakeholder (individuals at their practices/institutions) comments for white papers for both the transparency/"incident to" and specialty issues.	• Created a two-page transparency issue brief to provide a high-level summary to chapter leaders and practicing PAs that might not read the longer paper. The commission reviewed and approved the brief. • GRPA reviewed and is in the process of providing feedback on the 7-page transparency paper which is aimed at pointing out the negative impact of a lack of identification /recognition of the services delivered by PAs. The paper looks at negative consequences of the lack of transparency for PA-provided care from the perspective of patients, PA employers, data collection efforts and PAs. Specific suggestions are provided in the paper to address transparency concerns relating to EHR systems, provider directories, eliminating problematic billing policies and updating claim processing systems. • GRPA discussed the issue of identification of PAs by specialty to Medicare, Medicaid and commercial payers, looking at the pros and cons of changing AAPA's traditional stance of not identifying PAs by specialty. A two-page internal discussion document was developed. The consensus by GRPA was not to change existing AAPA policy and not to offer an HOD resolution supporting PA identification by specialty at this time. AAPA reimbursement staff will continue to monitor the environment for information or external policy changes that might necessitate a review of this issue.
Have GRPA members present an AAPA-developed survey (5 questions max) to their billing/practice management personnel asking PA employers to indicate their top three PA reimbursement/practice management/EHR "pain points."	• The purpose of five question survey was to gather additional information in determining if PA employers were experiencing reimbursement concerns or barriers in which AAPA reimbursement staff was not actively involved. Asked GRPA members to send this to a couple of different levels of people in the revenue cycle at their employer because that redundancy will be

	beneficial. The responses received did not uncover PA reimbursement concerns not already being addressed by AAPA. One idea was to provide some type of update, perhaps a reimbursement alert, to inform PA-employers about important changes in payer policies when they occur. Such update alerts currently appear on the AAPA reimbursement web site.
Provide advice on AAPA's federal (congressional and regulatory) priorities.	• Updated on status of full practice authority at the VA from staff, as well as a commission member. • Update on LAS and the two issues featured on Hill Day, Direct Pay and Home Health. • Conversation about what AAPA doing in response to COVID-19 with the administration and congress. Asked commission members for advice on several items like more PPE, hazard pay, liability, etc.
Analyze and provide comments on AAPA policies assigned by the House Officers, to include but not limited to five-year policy review, and develop recommendations for consideration by the appropriate body.	• Worked with COs and federally employed PAs on policies assigned to GRPA for review. • Decided not to put forward a new policy related to specialty designation. • Rewrote several policy papers.
Collaborate with other commissions, organizations and staff, as needed, to ensure cross-organizational strategy, research and planning processes.	• Worked with HOTP on several policies assigned to the commissions for joint review. • Worked closely with the PAs in Disaster Medicine to rewrite the PA in Disaster Response: Core Guidelines paper. • The communications department briefed the commission on work doing to assist states, how incorporate "Your PA Can Handle It" campaign and our overarching communications strategy. • Received an educational update on GAIN and Key Contact program, as well as the PAC along with encouragement for commission members to engage with their elected officials.

Other	• Discussion on reworking the 6 Key Elements and possibly combining with OTP. Some think the 6 key elements should go away altogether, focusing only on aspects of OTP. While others say there must be something achievable for all states or that this should be a tool for employers. Agreement benchmarks are still needed to show other states why these elements should be removed. There is a real population of PAs and lawmakers who simply would not see the utility of OTP at all. Keeping the other elements in helps to not alienate those people. It is part of the evolution. • Discussed our work in the states during COVID-19 and requests for executive orders waiving supervision and other barriers to PAs responding to the crisis and the resources we have provided on our website. Asked commission members to get PAs to write down their stories/experiences, so we can prove there is no reason to have these regulatory encumbrances, and when they are removed, everyone will be better off. Discussion on what data can we get out of this. Discussed increased need for interstate compact and also problems with PAs providing telemedicine due to supervision requirement.

Strategic Outcomes and Considerations:

Despite the challenges proffered by a global pandemic, the members of the committee gave generously of their time to address the items iterated above. Particular attention has been made to ensure language is applied that ensures the PA profession is not unduly restricted in our ability to respond to the health and wellbeing of our patients, practices and communities. Each volunteer was timely, thoughtful and efficient in the review of the assigned policies and offered their specific insight to robust discussions. The staff were of great help and are largely responsible for many years long planning that resulted in the organization's ability to nimbly assert policies when the opportunities presented themselves. We are fortunate to have been comprised of lifelong advocates as well as those in a position to carry the commission forward for many years. There was unanimity in the review and revision of the policies and position statements cited and we believe they will be received well by the vast majority of members.