June 26, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 123,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the 2019 Inpatient Rehabilitation Facility Prospective Payment System proposed rule. This proposed rule seeks to collect information regarding the education, training, and quality of care provided by "non-physician" health professionals, such as PAs, to determine whether the role of these health professionals can be expanded in Inpatient Rehabilitation Facilities (IRFs). It is within this context that AAPA provides comments attesting to the education, expertise and capability of PAs to deliver a wide range of high quality, patient-centered care in rehabilitation facilities.

At present, certain Code of Federal Regulations (CFR) sections regarding IRFs use physician-centric language when establishing care delivery requirements. 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. Meanwhile, §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. However, to address a concern about regulatory burdens in IRFs, CMS has expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs and nurse practitioners (NPs) to fulfill some of the requirements previously assigned only to rehabilitation physicians.

AAPA fully supports 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 in rehabilitation hospitals. Allowing PAs to provide care they are educated and qualified to perform will ease both regulatory burden, as well as increase patient access due to the availability of additional health professionals. Research conducted by the Association of American Medical Colleges estimates that, by 2030, the United States will experience a shortage of between 40,800 and 104,900 physicians.[1] This shortage is often attributed to a confluence of trends such as an increase in population size, more individuals covered by health insurance, a progressively older population, improved life expectancy, and physician retirements. These shortages have led, and will continue to lead to, increased wait times for care and in some cases a lack of access to care. In a survey of 15 large metro markets, the average patient wait time for an appointment with a health professional has grown 30% from 2014 to 2016 to 24.1 days.[2] In the proposed rule, CMS

[1] https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/
[2] https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf

postulates as to whether remote visits may help mitigate access concerns in rural areas. While AAPA approves of telemedicine to help address access issues, we view this option to be supplementary. A better, more immediate solution to the physician shortage is the expanded use of PAs (and NPs) who are willing and fully qualified to work in these settings.

The increased use of PAs, authorized to provide care to the full extent of their scope of practice, will help offset deficiencies in physician supply. The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics (2017), with a projected 37.4% increase in PAs by 2026.[3] These growth projections suggest adequate utilization of PAs will continue to be an effective method of combatting access concerns. This is validated by research that demonstrates when PAs are added to healthcare practices, PAs increase patient access and decrease wait times for appointments.[4,5]

Access issues due to physician shortage are also more severe in select geographic areas, specifically in rural communities. Twenty percent of Americans live in rural areas but only nine percent of physicians practice there.[6] Ratios of patients to health professionals are generally significantly higher in rural areas than urban, which may negatively affect population health. Rural areas compound physician shortage issues with demographic trends, such as an aging population[7], and transportation difficulties, which may lead to poor adherence or delayed/missed appointments.[8] However, rural access barriers to care can be alleviated through use of PAs. PAs have a significant presence in rural settings. Over fifteen percent of PAs practice primary care in rural and frontier areas.[9] This number could increase if laws, regulations, and contractual agreements are structured in a way that encourages increased utilization.

CMS indicates that, in exploring the expansion of PA and NP utilization in IRFs, it continues to have questions as to 1) whether PAs and NPs have appropriate training to adequately assess the interaction of a patient's medical and functional care needs in an IRF, and 2) whether PAs and NPs will be able to provide the high-quality care necessary to treat complex conditions. AAPA will address each of these concerns as they pertain to PAs.

PAs have the appropriate training

Currently, more than 123,000 state-licensed PAs are practicing medicine throughout all fifty states and the District of Columbia. PAs provide quality healthcare to patients on a level comparable to physicians, confirmed both by research studies and federal program recognition, 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 234 PA programs that are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).[10] 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

[3] https://www.bls.gov/ooh/healthcare/physician-assistants.htm
[4] Dower & Christian, 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-NPPAModels.pdf
[5] Randolph et al., 2016 http://dx.doi.org/10.1097/01.JAA.0000490116.12185.59
[6] https://www.healthdatamanagement.com/news/telehealth-plays-growing-role-for-patient-access-to-care-in-rural-america
[7] https://www.urban.org/urban-wire/people-and-homes-are-aging-quickly-our-rural-communities
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/
[9] 2018 AAPA Salary Survey
[10] http://www.arc-pa.org/accreditation/accredited-programs/

department, inpatient, and the operating room. Programs average 26.3 months in duration and include approximately 2,000 hours of clinical rotations.[11]

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.[12] 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 generally rotate through nursing homes and rehabilitation facilities, outpatient geriatrics clinics, hospital consult services, assisted living facilities, wound care, palliative, and hospice care.

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.

A PA's education does not end at graduation. The PA profession is the only medical profession that requires a practitioner to periodically take and pass a comprehensive exam to remain certified, which PAs must do every 10 years. To maintain their certification, PAs must also complete 100 hours of continuing medical education (CME) every two years.

PAs already deliver care to acutely ill patients with multiple co-morbidities. More than 30% of all PAs work in a hospital setting routinely providing critical care services, surgical care and emergency medicine services to patients.

Finally, PAs practice in healthcare teams along with physicians. Consequently, time spent practicing with rehabilitation physicians has provided many PAs with direct rehabilitation experience to provide these services to IRF patients.

IRF patients will continue to receive high-quality care

In addition to being well-equipped to provide care, it's important to note PAs provide high quality medical care. Numerous studies show the quality of care PAs provide is comparable to that of physicians in terms of patient safety, outcomes, and mortality.[13,14,15,16] 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.[17,18,19] In addition, PAs perform procedures with similar safety, outcomes and accuracy as physicians.[20,21,22]

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[11] http://paeaonline.org/wp-content/uploads/2017/06/Program-Survey-31_V4_Updated-June-2017.pdf
[12] http://www.arc-pa.org/wp-content/uploads/2016/10/Standards-4th-Ed-March-2016.pdf
[13] Doan et al., 2011 http://dx.doi.org/10.1111/j.1742-6723.2010.01368.x
[14] Ho et al., 2010 http://dx.doi.org/10.1111/j.1445-2197.2010.05311.x
[15] Mains et al., 2009 http://dx.doi.org/10.1097/TA.0b013e31819d96d8
[16] Virani et al., 2015 https://www.ncbi.nlm.nih.gov/pubmed/26483105
[17] Dhuper & Choski, 2009 http://dx.doi.org/10.1177/1062860608329646
[18] Roy et al., 2008 http://dx.doi.org/10.1002/jhm.352
[19] Singh et al., 2011 http://dx.doi.org/10.1002/jhm.826
[20] Bevis et al., 2008 Retrieved from http://ajcc.aacnjournals.org

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.[23,24, 25,26] 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.[27] Finally, studies demonstrate PAs often care for the same patient medical complexity as physicians.[28]

The fact that PAs provide quality care is increasingly recognized by state laws, healthcare programs and policy makers. PAs are listed by the Affordable Care Act as one of three types of health professionals who deliver primary care services and are included among the list of health professionals that can be Eligible Clinicians under the Quality Payment Program from its inception. 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 cover services provided by PAs. PAs can provide similar services as those provided by physicians, within their state scope of practice.

In the proposed rule, CMS requested feedback on how the care of health professionals such as PAs and NPs could be authenticated. AAPA suggests that PAs are open to having those applicable quality measures used to assess physician quality also apply to the PA profession. PAs, as they practice medicine in a similar manner as physicians, would be able to adhere to the same quality metrics.

Due to the extensive education and training, as well as the level of care quality shown to be provided by PAs, AAPA requests CMS officially broaden CFR language regarding IRFs to permit PAs to provide the services that the agency currently only permits a physician to deliver. PAs are capable of providing services performed by rehabilitation physicians under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) and this expansion will improve patient access to care while maintaining care quality for IRF patients.

Thank you for the opportunity to provide feedback on the Inpatient Rehabilitation Facility Proposed Rule. AAPA welcomes further discussion with CMS regarding our position and comments. For any questions you may have regarding our comments and recommendations, please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

L. Gail Curtis, MPAS, PA-C, DFAAPA
President and Chair of the Board

[21] Horton et al., 2011 http://www.aanp.org/publications/jaanp
[22] Krasuski et al., 2003 http://dx.doi.org/10.1002/ccd.10491
[23] Hooker et al., 2005 https://www.researchgate.net/publication/265445650
[24] Cipher et al., 2006 Retrieved from http://journals.lww.com/jaapa/pages/default.aspx
[25] Roblin et al., 2004 https://journals.lww.com/lww-medicalcare/Abstract/2004/06000/Patient_Satisfaction_With_Primary_Care__Does_Type.10.aspx
[26] Counselman et al., 2000 http://www.ajemjournal.com/article/S0735-6757%2800%2918497-9/abstract?cc=y
[27] Dill, et al., (2013) http://dx.doi.org/10.1377/hlthaff.2012.1150
[28] Ellen T. Kurtzman et al., 2017 https://www.aapa.org/download/21803/