



September 14, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3260-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

The American Academy of Physician Assistants (AAPA), on behalf of the more than 104,000 physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments on the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities proposed rule. PAs provide care under Medicare and Medicaid in all 50 states and the District of Columbia. As the first comprehensive review and update to Long-term Care (LTC) facility policy since 1991, many modifications were made in this proposed rule to modernize the way in which healthcare professionals function and the manner in which patients are cared for. Many of these modifications directly affect PAs and the patients they treat. It is within that context that we draw your attention to our comments regarding CMS' planned modifications to LTC policy.

Since 1991, PAs have grown from a workforce of approximately 20,000 to over 104,000 and have been increasingly recognized by state and federal law as highly qualified healthcare professionals that are an important part of the solution to increasing access to care. PAs are an integral part of the healthcare system. Utilizing their broad medical training to help practices and healthcare organizations manage the growing demand for health services just makes good sense. Accordingly, AAPA is pleased with those provisions of the proposed rule that recognize the competencies and qualifications of PAs. However, as we point out later in our comments there are important aspects of the rule that still need to be changed in order to assure that PAs can provide appropriate and timely care to the patients they serve.

One way this rule recognizes the role of PAs is the recognition of PAs by CMS under the definition of "licensed health professional." CMS further promotes the recognition of PAs by revising sections of the regulations to require a facility to inform residents of the name, specialty, and contact information for the person who is responsible for his or her care. This language extends beyond merely the physician to include 'other primary care professionals.' We believe that the purpose of this change is to assure that health professionals, such as PAs, will be identified to LTC residents.

AAPA applauds the transparency and accountability of such revisions. To maintain this level of transparency, AAPA recommends that CMS expand this concept by requiring official PA enrollment in all state Medicaid programs as is done under the Medicare program. While all state Medicaid programs cover services provided by PAs, a limited number of states fail to officially enroll them and, therefore, are unable to track the medical and surgical services delivered by PAs.

AAPA also supports the provisions surrounding the issue of patient transfers. Specifically, the proposed rule indicates that PAs can perform in-person evaluations of residents prior to an unscheduled, non-emergent transfer to a hospital. The rule also allows a practitioner (such as a PA) other than the attending physician to determine that a hospital transfer is medically appropriate in an emergency situation, if consistent with state law and facility policy. Allowing such actions to be performed by PAs increases the efficiency of care provided to patients who require a change in location from an LTC facility in order to receive necessary care.

AAPA commends CMS' policy that PAs may order laboratory, radiology and diagnostic services, as allowed by state law. This was clarified from the previous position that an 'attending physician' had to order such services. AAPA further favors CMS' thinking that if a PA orders such services the PA must be notified of any abnormal results that fall outside of clinical reference ranges in accordance with facility policies and procedures for

notification of a practitioner or per the ordering PA's request. While CMS' intent seems clear and is spelled out on page 42171, we did notice that not all necessary language changes were made in the appropriate section on page 42262. In what appears to be an oversight, two mentions of "physician's orders" were not altered to include the various other practitioners who can order and receive the results (see the end of Sections 438.50(a)(2)(ii) and 438.50(b)(2)(ii)). We request that these final modifications be made in order to harmonize statements on the issue. With that correction made, AAPA views these policy changes as increasing care efficiency by allowing PAs to order medically necessary diagnostic services and receive the test results.

However, while CMS makes great strides toward PA inclusion in the proposed rule, there are some provisions in which the language falls short. Although CMS appropriately prioritizes notification of PAs of laboratory, radiology and diagnostic services, there are other areas in which the rule explicitly mentions that a physician is to be notified with updates relevant to the patient with no mention of other healthcare professionals. For example, the rule indicates that the facility must notify the resident's physician when there is a change in a resident's status. Such limiting language potentially excludes a PA that may have primary responsibility for the patient and thus would be the most appropriate person to notify. Not only does this negatively influence the efficiency of care provision, but it could also impair quality and continuity of care if the PA responsible for the patient is not provided with all relevant information for diagnosis and treatment in a timely manner. Consequently, AAPA strongly recommends that this language be broadened to specifically include PAs.

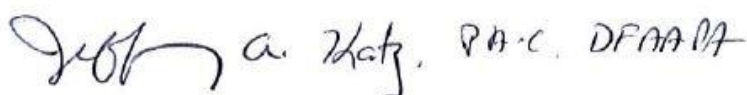
Another provision of the proposed rule that uses restrictive language is CMS' indication that an attending physician documents in the resident's medical record that he or she has reviewed an identified irregularity from a drug regimen and what, if any, action they have taken to address the issue. Again, despite the ability of PAs to prescribe medications in all 50 states and the District of Columbia, there is no mention of a PA's ability to review subsequent irregularities and determine appropriate action. If a PA had been the prescribing provider, that PA would be in the best position to resolve the issue.

Regarding dietary considerations for LTC patients, AAPA appreciates CMS' proposed policy that a facility may not charge for special food and meals ordered for a resident by various providers, including PAs. However, this concept is weakened by a different provision of the rule which restricts to physicians the ability to delegate dietary orders to dietitians. If CMS exhibits confidence in the personal orders of PAs regarding meals, then it logically follows that PAs should be authorized to delegate such orders to appropriate providers as well. There is also similar limiting language regarding the delegation of therapy orders to therapists. The language is physician-centric. There is no rational reason to limit PAs from delegating therapy orders. PAs should be able to delegate therapy orders to patients in LTC facilities.

Finally, AAPA is concerned that the proposed rule includes restrictive language regarding patient admission to, and discharge from, a facility. The rule states a physician recommends admittance to a facility and that a physician documents the need for discharge if the facility is unable to meet a patient's needs. While PAs are authorized to provide an order for immediate care needs upon admission, the actual act of admittance or documenting the need for discharge is unnecessarily limited to physicians. In the interest of assuring that patients receive timely and proper care in the most appropriate healthcare setting, AAPA recommends that CMS modify this language to explicitly permit PAs to perform these services. Increasingly, PAs are the primary or sole healthcare professional for patients, especially in rural and underserved communities. Not allowing PAs to function to the full level of their education and expertise will harm their ability to extend needed care to patients.

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

Respectfully,



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President and Chair of the Board