



August 15, 2016

Andrew M. Slavitt Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services Attn: CMS-3295-P
P.O. Box 8010
Baltimore, MD 21244

Re: File Code-CMS-3295-P; Medicare and Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

Dear Administrator Slavitt,

The American Academy of PAs (AAPA), on behalf of the more than 108,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on *the Medicare and Medicaid Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care* proposed rule. PAs are an integral part of the solution to ensure Medicare beneficiaries have access to high quality medical care. As more individuals enter into the Medicare program and physician shortages continue to worsen, obtaining appropriate and timely access to care is likely to become even more challenging for this patient population. PAs are an essential part of the healthcare delivery system and will, if not impeded by inefficient and restrictive rules and regulations, continue to improve access to care within the Medicare program.

Licensed Practitioners

AAPA applauds CMS for proposing a policy change that puts patients first by removing confusing and antiquated language that potentially limits hospitals from utilizing PAs to the full extent of their education and expertise. The proposed rule would change the term “licensed independent practitioner,” which appears in several CMS regulatory citations and hospital Conditions of Participation (CoP), to “licensed practitioner” in describing which health professionals have the ability to order restraint and seclusion in hospitals. In the past, some hospital administrators and personnel were confused as to whether PAs were included among those professionals who were allowed to order restraint and seclusion due to the word “independent” appearing in regulatory language. The proposed language change will remove that uncertainty and clearly demonstrate that PAs are authorized to order restraint and seclusion, in accordance with state law and facility policy, when medically necessary to protect patients and health professionals.

The term “licensed independent practitioner” is a phrase that is not used in the Social Security Act or in any federal statute. In previous comments to and meetings with CMS, AAPA recommended that the word, “independent,” be struck from any term describing qualified healthcare professionals. “Independence” is not a measure of a healthcare professional’s educational preparation, competency, or ability to provide quality medical care. Eliminating this term, which has limited the ability of PAs to deliver needed care to patients, supports patient access to care, moves further toward a team-based healthcare delivery model and recognizes the need to fully utilize the healthcare workforce. AAPA values CMS’ recognition that PAs have the education and expertise to provide this level of care with a high degree of autonomy and as CMS noted in the proposal, “PAs are trained on a medical model that is similar in content, if not duration, to that of physicians.”

In addition, we agree with the removal of the term “physician assistant” from the current provisions at Code of Federal Regulations §482.13(e)(12)(i)(B) and (e)(14). The inclusion of PAs in these sections is not appropriate as it erroneously equates PA scope of practice with that of registered nurses and gives the false impression that there are restrictions or limitations on PA scope of practice and how hospitals are authorized to utilize PAs. This change will clarify that PAs have ordering authority similar to that of physicians.

In Accordance with State Law

PAs always deliver medical care in accordance with state laws and regulations. It is important to understand that PA state law does not include a listing of each of the hundreds of services and procedures PAs are authorized to perform. The scope of practice language found in most PA state laws is less specific and generally mirrors that of the PA’s collaborating physician. For that reason it would be unusual to expect to find a PA state law that individually listed the ordering of restraint and seclusion as part of a PA’s scope of practice. Generally speaking, if a medical or surgical duty/responsibility is within the PA’s level of education and expertise, delegated to the PA by the physician and within the physician’s scope of practice then PAs are authorized to provide that service. There are occasional, special provisions in state law that guide PA practice in certain clinical situations, such as with the use of ionizing radiation. But overall, PA scope of practice is very broadly defined.

Previous Interaction with CMS on Ordering Restraint and Seclusion

We acknowledge that CMS has made previous attempts to explain that PAs had the ability to order restraint and seclusion in accordance with state law and hospital policy. A CMS rule dealing with Patients’ Rights Conditions of Participation, effective January 8, 2007, gave authority to a physician to delegate the ordering of restraint or seclusion to a PA, however that language, which appeared in the preamble of the rule, was often overlooked or overshadowed by the more limiting “licensed independent practitioner” language that appeared in the hospital Conditions of Participation and in many cases was a barrier to full PA utilization.

AAPA fully supports the CMS proposal to replace the term “licensed independent practitioner” with the term “licensed practitioner” to clarify that PAs are authorized to order restraint and seclusion in hospitals.

Medical Records

In the proposed rule, CMS seeks to make changes and clarifications to patient medical records requiring that all records “document discharge and transfer summaries with outcomes of all hospitalizations, disposition of cases, and provisions for follow-up care for all inpatient and outpatient visits to reflect the scope of all services received by the patient.” CMS hopes that this increased focus will clarify the importance of discharge summaries for patients going home and transfer summaries for patients being sent to post-acute care facilities. AAPA supports this effort to improve communication between providers and facilitate transitions of care.

PAs are often tasked with the responsibility of writing discharge summaries for patients who are leaving the hospital from an inpatient or outpatient status. Language found in the Medicare Interpretive Guidelines require that a physician co-sign the medical record when PAs have written discharge summaries, although there is no statutory authority for this “requirement.” The imposition of this arbitrary requirement represents another example of language that appears not to be supported by statute or regulation that has been imposed upon physicians, PAs and advanced practice nurses (APRNs). This requirement has a net impact of creating practice inefficiencies and administrative burdens for PAs and APRNs, as well as the hospitals that must ensure compliance. In addition, there is no evidence or indication that patients are better served due to this co-signature requirement.

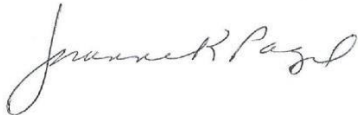
AAPA has been advised by the CMS Clinical Standards Group/Center for Clinical Standards & Quality that physician co-signature of discharge summaries is not required by law. However, the CMS Survey and Certification Guidance (Medicare Interpretive Guidelines), upon which CMS surveyors often rely, requires a physician co-signature on hospital discharge summaries. Here is the problematic language found at TAG A-0468:

“Whether delegated or non-delegated, we would expect the person who writes the discharge summary to authenticate, date, and time their entry and additionally for delegated discharge summaries we would expect the MD/DO responsible for the patient during his/her hospital stay to co-authenticate and date the discharge summary to verify its content.”

In the interest of administrative simplification, and to align with the actual regulation, we strongly recommend the removal of the instructions for standard §482.24(c)(4)(vii) at TAG A-0468 that require physician co-signature when PAs complete discharge summaries.

AAPA appreciates this opportunity to provide feedback on the Changes to Promote Innovation, Flexibility, and Improvement in Patient Care proposed rule and welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. For any questions you may have in regard to 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,

A handwritten signature in cursive script that reads "Josanne K. Pagel".

Josanne K. Pagel, MPAS, PA-C, Karuna® RMT, DFAAPA
President and Chair of the Board