PHYSICIAN ASSISTANTS IN HOSPICE AND PALLIATIVE MEDICINE

September 2, 2019

Seema Verma Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

RE: 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies **CMS–1715–P**

Dear Administrator Verma,

Physician Assistants in Hospice and Palliative Medicine (PAHPM) is a group that represents physician assistants (PAs) nationally who are clinicians, educators, researchers, and leaders in the fields of hospice and palliative medicine. PAHPM appreciates the opportunity to comment on the CY2020 Medicare Physician Fee Schedule Proposed Rule changes that pertain to both PA supervision as well as PA practice in hospice care. In 2019, we welcomed the change to include physician assistants (PAs) within the definition of hospice "attending physician" (42 CFR part 418). However, as many other stakeholders have commented, the limits in § 418.106(b)(1) that exclude PAs from prescribing drug orders for hospice patients limits a successful "attending physician" to provide quality care and continuity for our patients on hospice.

Therefore, **PAHPM agrees with CMS's proposal "to revise § 418.106(b)(1) to permit a hospice to accept drug orders from a physician, NP, or PA. We propose that the PA must be an individual acting within his or her state scope of practice requirements and hospice policy."** As an "attending physician," PAs must not have unnecessary barriers to work with hospices to fully participate in the symptom management of conditions related to their terminal diagnosis and the full care of our patients

PAHPM respectfully disagrees, however, with the proposal to specifically limit reimbursing PAs with whom hospices may want to employ or contract. As noted in our comments below, PAs have demonstrated their ability to care for patients at the end of life, in a variety of settings as palliative care providers. We have nationally accredited training which requires end-of-life education, and have demonstrated that we can provide quality care at the end of life. Hospices have consistently shared with us that they agree: current hospice rules and regulations arbitrarily restrict our growth into the field. They have shared how our skills and competencies could add to their interdisciplinary teams (IDTs), share in leadership roles, and more importantly, provide quality symptom management and care for patients in the setting of a field which has demonstrated severe current and future workforce shortages.

We understand that the PA role has not been historically defined by existing CoPs and statutes, and that the overall role of non-physician providers (NPPs—NPs and PAs) or advanced practice providers (APPs) which is the more commonly accepted term, needs to be examined and modernized. *Physician assistant education, skill, competence and compassion have never been barriers to our ability to practice as hospice clinicians—only the regulations under which hospice has been guided.* We hope our responses below to CMS' specific questions pertaining to the roles of APPs will help demonstrate not only the appropriateness to include PAs as members of the full hospice team, but the need of our health system to continue to provide access to quality end-of-life care for patients and their families.

- *What is the role of a NPP/APP in delivering safe and effective hospice care to patients? What duties should they perform? What is their role within the hospice interdisciplinary group and how is it distinct from the role of the physician, nurse, social work, and counseling members of the group?*

The *Clinical Practice Guidelines for Quality Palliative Care, 4th edition*., updated and released in 2018 clearly defines recommendations for IDTs to include APPs: "a team of physicians, advanced practice registered nurses, physician assistants, nurses, social workers, chaplains, and others based on need"[1] Each of these disciplines, including PAs, should be allowed to practice to the top of their licenses. Advance practice nurses and PAs have demonstrated competence and skill in providing not only palliative care, but end-of-life care in inpatient and outpatient settings for decades. They currently provide complex symptom management, goals of care conversations, and support for patients and their families, and they are integral members of the palliative care teams on which they work. They work as clinicians, educators, and in leadership roles. They should be allowed to provide the same level of support and care on hospice teams. They should be allowed to admit patients to hospice, certify and recertify patients with a terminal illness. They should be allowed to provide ongoing management and care.

- *Nursing services are a required core service within the Hospice benefit, as provided in section 1861(dd)(B)(i) of the Act, which resulted in the defined role for NPs in the Hospice COPs. Should other NPPs/APPs also be considered core services on par with NP services? If not, how should other NPP/APP services be classified?*

In current clinical practice, NPs, CNS, and PAs all have similar job descriptions and the same work expectations. They are expected to work at the top of their licenses. **Physician assistants should be included along with our nursing counterparts as our training and experience is comparable**. All PAs are required to have palliative skills and "end-of-life" care training as part of our national accreditation requirements.[2] Physician assistants are currently practicing specialist level palliative care and end-of-life care in a variety of inpatient and outpatient settings, and have demonstrated the ability to expand access and quality to more patients in more settings.[3,4]

- *In light of diverse existing state supervision requirements, how should NPP/APP services be supervised? Should this responsibility be part of the role of the hospice medical director or other physicians employed by or under contract with the hospice? What constitutes adequate supervision, particularly when the NPP/APP and supervising physician are located in different offices, such as hospice multiple locations?*

Our states' PA laws have already moved away from the term "supervision" to describe the PA-physician relationship. For continuity of care and administrative simplification, it is essential that Medicare policy be consistent with laws promulgated by the state so PAs can continue to deliver care to their Medicare patients. PAs are authorized to provide medical and surgical care to Medicare beneficiaries in all 50 states and the District of Columbia. PAs are committed to increasing access to high quality care for all Medicare beneficiaries and we seek to work in partnership with the CMS in both the development and advancement of thoughtful policies that help in achieving that goal. To accomplish this goal, it is essential that Medicare's policies authorize PAs to practice at the top of their education and expertise. In the absence of state law governing physician supervision of PA services *a PA should document at the practice the relationship that they have with physicians to deal with issues outside their scope of practice*.

The December 2018 federal government report on healthcare competition entitled, Reforming America's Healthcare System Through Choice and Competition, specifically recommended that "States should consider eliminating requirements for rigid collaborative practice and supervision agreements . . . that are not justified by

legitimate health and safety concerns." It is essential that the federal Medicare program promote regulations that closely align with those state actions to ensure continuity of care for Medicare beneficiaries.

PAHPM agrees with CMS that changes do need to be made to bring current regulations in line with existing language that mirrors physician collaboration for NP and CNS services. Physician assistants rarely require direct supervision in any setting, and hospice does not necessitate an exception. Practicing within state guidelines, CMS should allow all APPs to collaborate with our physician colleagues both employed and contracted by hospices. Hospices have standards and hospice medical directors who currently provide supervision for all IDT members. Hospices already have models of collaboration with the existing rules around NPs completing face-to-face visits for re-certification with physician collaboration. There is no reason a PA could not complete this same role and collaboration. Given the current national workforce shortages of all hospice providers which are expected to continue, we would encourage CMS to create language that allows APPs to practice to the top of their license and education, and to collaborate with our colleagues and other members of the IDT.[5,6] This will help provide quality care, while also being flexible for the changing landscape of models of care for hospice which may include telemedicine in rural areas, home-based palliative to hospice models of care, and changes needed to meet the needs for access in rural areas. There is already precedent for this with most states allowing for flexible regulations for PAs needing to provide emergency care and medication ordering in rural areas without direct supervision.

- *What requirements and time frames currently exist at the state level for physician co-signatures of NPP/APP orders? Are these existing requirements appropriate for the hospice clinical record? If not, what requirements are appropriate for the hospice clinical record?*

As PAs, we do not require physician co-signature for any other specialty, and it seems unnecessary to require this for hospice. While we would recommend that the ability to provide certification and recertification of terminal illness need not be unnecessarily limited to physician providers, we believe that if this remains the case, all APPs should have the same standard and expectations given that while we have distinct training and sometimes roles, we all provide comparable skill and care as discussed above.

- *What are the essential personnel requirements for PAs and other NPPs/APPs?*

Physician assistant education is unique and distinct from advance practice nurse training, but comparable in many ways. Our more than 50 years as a profession have evolved into patient care in nearly all specialties in medicine. Comprehensive master's degree programs provide PAs with a rigorous generalist medical education curriculum modeled on medical school. During the classroom phase, PA students take more than 75 hours in pharmacology, 175 hours in behavioral sciences, more than 400 hours in basic sciences and nearly 580 hours of clinical medicine. This is followed by clinical rotations in family medicine, internal medicine, general surgery, OBGYN, emergency medicine, pediatrics, and psychiatry. PA students complete at least 2,000 hours of supervised clinical practice by the time they graduate. As noted earlier, PA program accreditation standards require education in palliative and end-of-life care.

After graduation, PAs must pass a national certifying exam and obtain a state license. Similar to physicians to maintain certification, PAs complete 100 hours of continuing medicine education (CME) every two years and must pass a national recertification exam every 10 years.[4]

The combination of education, certification requirements, state licensing medical board requirements, and employer credentialing processes provides ample opportunity to review the PA practice and to provide quality palliative and hospice care. While it is necessary to have methods for verifying competence and

skill, something PAs do as they enter the workforce daily in nearly every medical specialty, we would advise caution for development of any strict guidelines for certification. This needs to be a thoughtful and a flexible process so as not to inadvertently limit the workforce more as has been demonstrated by current limits on physician training and board certification. All providers (physicians, APPs, and other members of the IDT) should be a part of discussions on clinician competency standards and expectations.

PAHPM again thanks CMS and others for allowing us to be a part of the discussions around modernizing hospice care in the United States. We strongly believe PAs have a role within the current and evolving hospice model of care. There is evidence in support of including PAs in end-of-life care, and support from a wide body of stakeholders including patients, families, hospices and members of IDTs nationally. No one single provider group will be able to meet the need for quality end-of-life care in the US in the future, and PAs should be part of the multidisciplinary solution to the hospice and palliative workforce shortage facing our nation.

Thank you for your time and consideration of these comments. Please feel free to reach out to our group at PAPHM at info@pahpm.org.

Respectfully,

Physician Assistants in Hospice and Palliative Medicine (PAHPM)
PAHPM.org

References Cited:

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