American Academy of PAs

AAPA Statement for the Record Submitted to the House Ways and Means Committee Field Hearing: "Empowering Native American and Rural Communities"

May 10, 2024

Dear Chairman Smith, Ranking Member Neal and members of the committee:

On behalf of the more than 168,000 physician associates/physician assistants (PAs) throughout the United States, the American Academy of Physician Associates (AAPA) thanks the committee for your ongoing commitment to ensuring all Americans have access to high-quality healthcare. AAPA appreciates the opportunity to submit comments for the record with respect to the committee's May 10, 2024, Field Hearing on Empowering Native American and Rural Communities.

AAPA recognizes the complex and multifaceted issues and challenges facing the healthcare workforce in the United States, especially on the heels of a global pandemic and record levels of burnout. As our nation's population continues to age and additional factors, such as rising chronic disease, increase demand for healthcare services, we are confident that PAs are an integral part of the solution. The PA profession was established in the 1960s at a time when the nation was facing a primary care shortage and was founded to improve access, especially in rural and underserved communities.[1] Today, PAs remain ready to respond to the national demand for greater access to high-quality healthcare services. PAs already possess the medical education, training, and experience to do so.

As Congress considers policies to ensure timely access to high-quality care for all patients, AAPA encourages the committee to embrace opportunities to reduce provider barriers and burdens wherever they interfere with optimizing patient care and access. AAPA also encourages the committee to reauthorize current programs to address workforce challenges and enact legislation to ensure all providers can practice to the top of their license and education. Although PAs are already providing high-quality care across the nation and in all medical specialties, outdated barriers to practice remain. AAPA stands ready to work with the committee as you consider new ideas to ensure quality care is available to all Americans, particularly those in rural and underserved communities.

[1] Cawley JF, Cawthon E, Hooker RS. Origins of the physician assistant movement in the United States. JAAPA. 2012 Dec;25(12):36-40, 42.

Background: What is a PA?

PAs are medical professionals who diagnose illness, develop, and manage treatment plans, prescribe medications, and are often a patient's primary healthcare provider. PAs are highly trained professionals with thousands of hours of medical education and training who practice in all medical and surgical specialties in all 50 states, the District of Columbia, U.S. territories, and in the uniformed services. Additionally, PAs are one of three healthcare professions, including physicians and advanced practice registered nurses (APRN), who are recognized in Medicare to provide both primary and mental health medical care in the United States. The typical PA education program provides students with an intensive, master's degree level, medical education over approximately three academic years, or 27 continuous months.[2] However, PA education does not end with graduation. To practice, PAs must pass the PA National Certifying Examination and obtain state licensure. To maintain certification, PAs must also complete 100 hours of continuing medical education (CME) every two years and pass a comprehensive examination every ten years.[3] Many PAs seek additional educational opportunities following graduation and throughout the duration of their careers.

For more than 50 years, PAs have provided high-quality, cost-effective healthcare services to patients across the nation. However, several barriers remain at the state and federal levels that prevent PAs from practicing to the full extent of their education, training, and license. These barriers diminish the value PAs can bring to rural communities suffering from ongoing shortages of qualified healthcare providers.

According to the Health Resources and Services Administration (HRSA), more than 15% of Americans live in rural areas, but only 10% of physicians practice in those communities.[4] About 16% of all clinically practicing PAs are located in a rural county, with more than 1 in 3 practicing much needed primary care in rural locations. Removing barriers to ensure PAs can practice to the top of their license should be viewed as an important solution to the shortage of providers along with adequate access to primary care in rural and underserved areas.

Diabetic Shoes

PAs diagnose and treat illnesses, manage complex conditions, prescribe medications in all 50 states, and assist in surgery – but the current statute governing Medicare does not authorize PAs to complete the simple task of ordering diabetic shoes. With the aging U.S. population and increasing prevalence of diabetes, it is absurd that a PA can manage a patient's diabetes and other complex chronic conditions but is not authorized to order diabetic shoes. *The Promoting Access to Diabetic Shoes Act (H.R. 618/S.131)* will modernize current Medicare policy and authorize PAs to certify a patient's need for diabetic shoes.

A study published in the American Journal of Medicine in 2018 found that PAs perform as well as physicians in the management of diabetes at diagnosis and during four years of follow-up care. PAs are federally recognized primary care providers and frequently manage care for diabetics who may have multiple comorbidities. Outside of the Medicare program, PAs can certify the need for diabetic shoes for their patients. This is an example of the Medicare statute not making common sense or keeping up with how medicine is practiced today.

Diabetic foot complications are directly related to poor clinical outcomes and substantial cost, especially among rural Medicare patients. Compared to urban populations, rural populations have a 16 percent higher prevalence of type 2 diabetes, a 20 percent higher type 2 diabetes-related hospital mortality, and smaller improvements in overall mortality rates in the past two decades.[5] It is further estimated that rural patients face a nearly 35 percent increase in major amputation following diabetic foot ulcers as compared to patients living in urban areas.[6]

[2] PAEA. Program report 35, Table 6, page 7

[3] NCCPA. Certified PAs: Improving health, saving lives, making a difference.

[4] HRSA. Designated HPSAs as of March 31, 2024.

[5] Dugani, Sagar et al. Diabetes Metab Res Rev. Burden and Management of Type 2 Diabetes Mellitus in Rural United States.

Often referred to among providers as the 'diabetic amputation loop', 19 percent of diabetic patients will then face a second amputation within one year and more than 37 percent within the first five years.[7] The cost of a lower extremity amputation (LEA) among Medicare beneficiaries is substantial and growing. It has been estimated that the mean annual reimbursement of all services for diabetic Medicare patients with an LEA was more than $49,000 in 2006, more than $51,000 in 2007, and more than $54,000 in 2008.[8]

Modernizing Medicare to authorize PAs to certify a patient's need for diabetic shoes, consistent with state law, will improve the quality and continuity of care available to diabetic patients, especially for those living in rural and medically underserved areas experiencing critical access issues and physician shortages.

Mental and Behavioral Healthcare Access

Our nation is currently facing a significant shortage of mental healthcare providers, and unfortunately this shortage is only projected to grow in the coming years. As front-line providers, PAs are recognized across the nation as high-need providers in mental health who play a critical role in expanding psychiatric care.[9] While some PAs practice in mental and behavioral health specialties including psychiatry, currently more than 30,000 PAs practice in primary care and *routinely provide mental healthcare to their patients*.[10] PAs in emergency and hospital medicine also treat patients with psychiatric symptoms and are often a first line provider for patients to access mental or behavioral health services. PAs also serve an essential role providing high-quality mental health services to veterans across the Department of Veterans Affairs (VA) system. It is imperative that PAs are authorized to practice to the full extent of their education, training, and experience to confront the growing need for behavioral and mental healthcare services.

As highly educated and qualified medical professionals, PAs practice in behavioral health facilities, hospitals, private practice, rural health clinics, community health centers, and prisons across the United States. With clinical expertise, medical training, and the initiative to help, PAs are on the ground in local communities. In 2018, the PA Foundation launched an inaugural *Mental Health Outreach Fellowship.*[11] This profession-driven initiative was the first phase of a wider mental health outreach effort that sought to connect PAs with community mental health needs.[12] In 2019, the first PA fellows reported training more than 1,500 people across the United States to recognize and respond to mental health needs in their communities.

Recognized in federal law as providers in opioid treatment programs, PAs are also instrumental in providing care for patients with substance use disorder (SUD) and surrounding mental, physical, and behavioral health concerns. Effective treatments for substance use disorders are available, but few patients receive the treatment they need. In 2019, only 12.1% of individuals with a SUD received treatment.[13]

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[6] Krepnek GH, Mills JL, Armstrong DG. A diabetic emergency one million feet long: disparities and burdens of illness among diabetic foot ulcer cases within emergency departments in the United States, 2006-2010.

[7] Liu R, Petersen BJ, Rothenberg GM, et al. Lower extremity reamputation in people with diabetes: a systematic review and meta- analysis. BMJ Open Diab Res Care 2021;9:e002325. doi:10.1136/ bmjdrc-2021-002325

[8] Margolis DJ, Malay DS, Hoffstad OJ, et al. Economic burden of diabetic foot ulcers and amputations: Data Points #3. 2011 Mar 8. In: Data Points Publication Series [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK65152/

[9] Medical Director Institute. The psychiatric shortage: Causes and solutions. National Council for Behavioral Health. March 28, 2017. Washington, DC. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_NationalCouncil-.pdf

[10] AAPA. 2020 PA Data Book

[11] https://pa-foundation.org/mental-health-outreach-reflecting-and-forging-ahead/

[12] https://pa-foundation.org/our-programs/mental-health-outreach-fellowship/

[13] https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/increase-proportion-people-substance-use-disorder-who-got-treatment-past-year-su-01/data

While rural and urban areas alike are dealing with an overdose crisis, 56 percent of rural counties lack access to a provider who can prescribe treatment.[14] PAs are authorized to prescribe controlled medications in all 50 states. Once granted, no state has ever rescinded PA authority to prescribe controlled medications. There has been no record of increased liability or malpractice claims due to PA prescribing of scheduled drugs, and professional liability insurers have not increased premiums when PAs have been granted authority to prescribe controlled medications.

Healthcare in the United States continues to evolve from a traditional, physician-centric model to a more streamlined, efficient, and patient-centric model and PAs are evolving with it. As our nation faces a severe shortage of behavioral health providers, including physicians, it is imperative that PAs and other qualified mental health providers are appropriately utilized to provide this necessary care. The COVID-19 pandemic and public health emergency (PHE) highlight just how critical a robust and secure healthcare workforce is to our nation's security and overall wellbeing. Access to high-quality, evidence-based healthcare is critical for positive patient outcomes and healthy communities. PAs and other providers throughout the United States have faced increased stress, high rates of burnout and challenges to their own mental health. PAs must also confront an increasing demand to provide critical healthcare services while physician shortages, especially in rural and low-income areas, continue to grow.[15]

Medicare Shared Savings Accountable Care Organization (ACO)

PAs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned as beneficiaries in that program. Under current law, Medicare fee-for-service beneficiaries are assigned to an ACO based on their utilization of primary care services furnished by a physician. However, individuals in rural and underserved communities often rely on PAs and other advanced practitioners. As a result, the physician requirement prevents Medicare fee-for-service beneficiaries in these communities from accessing the coordinated care provided by ACOs. It is essential that primary care services furnished by PAs and other advanced care providers count for purposes of ACO assignment. This encourages ACO formation in rural and underserved areas and allows healthcare providers to attain enough ACO beneficiaries to participate in the Medicare Shared Savings Program. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages and encourage the adoption of value-based care principles such as care coordination and population health.

The ACO Assignment Improvement Act (H.R. 7665/S.3939) will improve the way beneficiaries are assigned under the MSSP by also basing such assignment on primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists.

Cardiac and Pulmonary Rehabilitation (CR/PR)

Current law arbitrarily restricts the ordering and supervision of cardiac and pulmonary rehabilitation in Medicare. In 2018, Congress rightfully authorized PAs and other advanced practice providers to **supervise** cardiac and pulmonary (CR/PR) services but with a delayed implementation until 2024. However, PAs are still not authorized to **order** this critical service for their patients.

CR/PR services are an essential and proven tool in the management of patients with chronic respiratory conditions, those who have survived myocardial infarction (heart attack) as well as patients fighting chronic obstructive pulmonary disease (COPD.) CR/PR services have also been used to treat patients recovering from an active SARS-COV-2 infection. Despite the clinical implications and critical importance of this treatment, CR/PR services remain severely underutilized, especially among high-risk populations in rural areas.[16]

[14] AIR, Exploring Urban-Rural Disparities in Accessing Treatment for Opioid Use Disorder, November 19, 2021.

[15] https://www.aamc.org/media/45976/download?attachment

[16] Fleg JL, Keteyian SJ, et al. Increasing Use of Cardiac and Pulmonary Rehabilitation in Traditional and Community Settings: OPPORTUNITIES TO REDUCE HEALTH CARE DISPARITIES. J Cardiopulm Rehabil Prev. 2020 Nov;40(6):350-355. doi: 10.1097/HCR.0000000000000527. PMID: 33074849; PMCID: PMC7644593.

CR/PR services are offered through medically directed and supervised programs designed to improve a patient's physical, psychological, and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment, and outcomes assessment.

PAs are routinely on the front line in critical care environments, such as in hospitals, clinics, emergency rooms, and intensive care units. They are highly trained providers, qualified to order and supervise critical medical services. However, under current law only physicians may order and supervise CR/PR programs in Medicare. CR/PR services are proven to improve health outcomes for patients who have survived a heart attack and/or have chronic obstructive pulmonary disease (COPD) and can treat patients recovering from other chronic diseases, including COVID-19. However, this life-saving treatment is underutilized, especially in rural and medically underserved areas, because qualified providers such as PAs are unnecessarily and arbitrarily prevented from ordering and supervising CR/PR. Patients deserve the highest- care available; outdated restrictions like this only compound the challenge in areas where access issues and care disparities are particularly acute. *The Increasing Access to Quality Cardiac Rehabilitation Care Act (H.R. 2583/S.3481)* would authorize PAs to order this critical service for Medicare patients, especially those in rural areas.

Hospice and Palliative Care

In 2018, *the Medicare Patient Access to Hospice Act* was included in *the Bipartisan Budget Act of 2018* and broadened the Medicare definition of hospice "attending physician" to include PAs. This inclusion took effect in January of 2019 and was a necessary step in ensuring adequate access to hospice care for Medicare patients, especially those in rural and underserved areas.

PAs regularly function as a patient's primary healthcare provider. Frequently, it is the primary provider, acting in the role of a Medicare hospice attending physician, who helps with a patient's transition to hospice and subsequently assists in facilitating care received. However, PAs may not certify or re-certify terminal illness. PAs are highly qualified health professionals and should be authorized to perform these functions, consistent with state law, under Medicare. Further, PAs need to be authorized to perform the face-to-face encounter that is required prior to recertification after a patient has been under the hospice benefit for 180 days. NPs, however, *are* authorized to perform this face -to-face visit that is then used by a physician to determine a patient's eligibility for recertification. These arbitrary restrictions on PAs remain a significant barrier to care for patients needing hospice services and are amplified in their detrimental effects by ongoing provider shortages. Our rural communities are facing a significant hospice workforce shortage that Congress could help alleviate. Authorizing PAs to certify and recertify terminal illness, in addition to perform face- to-face visits required for recertifications, something well within their scope and education, would significantly increase the number of highly qualified providers in the hospice workforce.

AAPA requests that Congress 1) modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs to certify and recertify terminal illness, and 2) modify 42 U.S.C. 1395f(a)(7)(D)(il) to authorize PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days.

Federal Workers Compensation

Currently, all US federal and postal employees receive workers compensation coverage for employment-related injuries and disease through the Federal Employees Compensation Act (FECA). However, FECA does not cover medical care provided by PAs (or nurse practitioners [NPs]) within the current definition of *"medical, surgical, and hospital services...,"* meaning once a federal or postal employee is injured on the job, they can no longer receive

healthcare from a PA, even if that PA is their primary care provider (PCP) through their federal health insurance program. This undue and unnecessary restriction negatively impacts our federal workforce, especially those in rural areas where access to any provider, not just physicians, can be challenging.

PAs provide high-quality healthcare and are recognized providers in Medicare, Medicaid, and nearly every state and federal healthcare program, including state workers' compensation programs. PAs are included in the definition of an *"acceptable medical source"* by the Social Security Administration and thousands of PAs are federal employees themselves and practice within the Department of Veterans Affairs, the Department of Defense, the Public Health Service, and Indian Health Services. FECA is the outlying federal program that does not recognize the critical role PAs play in our healthcare system. The *Improving Access to Workers' Compensation for Injured Federal Workers Act (H.R. 704/S.260)* would authorize PAs to treat their federally employed patients in accordance with state law.

Conclusion

In 2021, an AAPA Practice Survey[17] found that approximately half of the PAs who responded were already working in or interested in moving to practice in, a rural location, health professional shortage area, or medically underserved area. PAs are practicing in rural areas across the nation and while interest remains high, barriers and recruitment challenges remain. While PAs increase access to healthcare in rural areas, they also increase economic benefits in the same communities.[18] AAPA urges the committee to consider the vital role that PAs and other providers play in communities across the nation, specifically in rural and underserved areas, and ensure that they can provide the care that is so critically needed.

AAPA thanks the committee for the opportunity to submit these recommendations and for your ongoing dedication to our nation's healthcare systems. We are committed to working with Congress to advance our shared mission of improving access to healthcare in the United States. If we can be of assistance on this or any issue, please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at theuer@aapa.org.

[17] https://www.aapa.org/download/103451/

[18] Eilrich FC. The economic effect of a physician assistant or nurse practitioner in rural America. JAAPA. 2016;29(10):44-48. doi:10.1097/01.JAA.0000496956.02958.dd