American Academy of Physician Associates

AAPA Statement for the Record to the House Ways and Means Committee on Hearing: "After the Hospital: Ensuring Access to Quality Post-Acute Care"

March 24, 2025

Dear Chairman Smith, Ranking Member Neal, Subcommittee Chairman Buchanan, Subcommittee Ranking Member Doggett, 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 March 11 hearing on *After the Hospital: Ensuring Access to Quality Post-Acute Care*.

As our nation's population continues to age and additional factors such as rising chronic disease increase demand for healthcare services, including post-acute care, 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.

PAs are licensed clinicians who practice medicine in every specialty and setting. PAs diagnose illness, develop and manage treatment plans, manage their own patient panels, and often serve as a patient's primary healthcare provider. PAs practice medicine in every state, the District of Columbia, and all U.S. territories. PA scope of practice is determined by the PA's education and experience, state law, facility policy, and the needs of patients. Studies reinforce that PAs provide high-quality care, and patients have consistently indicated high-levels of satisfaction with PAs, comparable with care delivered by physicians.[2] Patients have also already demonstrated confidence and trust in the PA profession by indicating the type of health professional who provides care is less important than when they obtain access to quality care.[3]

As the Committee considers policies to ensure access to high-quality post-acute care, AAPA encourages you to embrace opportunities to reduce barriers and burdens that affect patients and

[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.
[2] Hooker RS, Moloney-Johns AJ, McFarland MM. Patient satisfaction with physician assistant/associate care: an international scoping review. *Hum Resour Health*. 2019 Dec 27;17(1):104.
[3] Dill MJ, Pankow S, Erikson C, Shipman S. Survey Shows Consumers Open To A Greater Role For Physician Assistants And Nurse Practitioners. *Health Affairs*. 2013 Jun; 32 (6).

providers wherever they interfere with optimizing patient care and access. Although PAs are already providing high-quality care across the nation and in all medical specialties, outdated barriers to practice remain.

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. However, there are ongoing barriers to accessing care that result in inappropriate delays to hospice services. Barriers to hospice can lead to a prolonged patient usage of expensive and ineffective care. Proper utilization of PAs will help ensure that hospice organizations are appropriately staffed with health professionals who can provide a broad array of services, increasing capacity and bolstering value of the benefit to patients and their families.

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, currently, PAs and nurse practitioners (NPs) are unable to certify/recertify a patient's terminal illness. In addition, PAs are not authorized to conduct a face-to-face encounter that is required prior to recertification after a patient has been under the hospice benefit for 180 days. PAs who work for a hospice are also prohibited from ordering medications for patients. In addition, if a beneficiary does not have a physician, NP, or PA who provided primary care to them prior to, or at the time of, terminal illness, the beneficiary is given the choice of being served by either a physician or NP (but not a PA) who works for the hospice as an attending physician. These policies unnecessarily limit the number of PAs that can fill the important role of an attending physician under specific circumstances.

PAs are highly qualified health professionals and should be authorized to perform these functions, consistent with state law. 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. There is no clinical justification for continuing these outdated policies. Making these changes would significantly increase the number of highly qualified providers in the hospice workforce, including in rural and underserved areas.

AAPA recommendation:

- Modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs and NPs to certify and recertify terminal illness.
- 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.

- Work with the administration to modify 42 CFR § 418.106(b)(1)(iii) to authorize PAs employed by the hospice to order medications for hospice patients.
- Work with the administration to modify the Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3, to authorize PAs employed by the hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient.

Skilled Nursing Facilities (SNF)

Arbitrary restrictions on patient access to SNF services limit the type and frequency of care provided by PAs. Specifically, PAs are not recognized by Medicare for the purposes of performing the initial comprehensive visit to SNF patients and are required to alternate every other required visit to SNF patients with physicians. Such restrictions are not based on medical evidence but are merely a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring greater efficiency to the system. PAs should be authorized to perform the initial visit, as well as to perform all required visits, in SNFs.

PAs remain clinically prepared, educated, and competent to deliver the full range of needed clinical care in SNFs. Current requirements necessitate physician involvement that may not be readily available in rural settings, or available in a timely fashion in high-demand settings. Allowing PAs to provide these services will expand patient access to needed care, as patients will no longer have to wait to see a physician when a PA is available.

AAPA recommendation:

- Work with the administration to revise policies found in 42 CFR § 483.30 that mandate that certain visits in SNFs be furnished only by a physician, including the initial visit and admission orders.

Inpatient Rehab Facilities (IRF)

Currently, §412.622(a)(3)(iv) identifies the need to 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. However, language contained in this section also requires that for the first week, a physician must do all three, and in each subsequent week, a non-physician health professional such as a PA or NP may only do one of the three visits per week. In addition, section, §412.622(a)(4)(ii), requires a rehabilitation physician to develop wanting to briefly sa plan of care for a patient within four days of admission. Requiring a physician to perform these duties is unnecessary and inefficient. PAs and NPs are qualified

to provide these services in full to meet patient demand. Such restrictive policies may also impact patient treatment if a patient is required to wait to see a physician for care that another health professional is qualified to provide and may reduce the benefits of provider continuity.

PAs should be authorized to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law. PAs are trained to treat rehabilitative patients in the course of their education. According to the Accreditation Review Commission on Education for the PA (ARC-PA) Standard B2.08, the PA 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.[4]

Students generally rotate through a variety of settings and specialties relevant to rehabilitation care, including nursing homes, rehabilitation facilities, outpatient geriatrics clinics, hospitals, assisted living facilities, wound care, and palliative and hospice care. Once practicing, Medicare authorizes PAs to order the type of care patients received in inpatient rehabilitation facilities (PT/OT/SLP) in outpatient and acute care hospitals, as well as develop a plan of care for such services. In an outpatient setting, PAs are further authorized to provide, certify, and supervise therapy services.[5]

Medicare's current authorization for PAs to provide services to these patients in an *inpatient* setting as well, although unfortunately and unnecessarily limited to one visit per week, further demonstrates that PAs can provide services to these patients. Granting authorization for PAs to provide all necessary patient visits, and to develop the plan of care in the inpatient setting, would give rehabilitation facilities maximum flexibility by providing them with the option to utilize appropriately qualified PAs in the same manner as rehabilitation physicians. This increased flexibility would ensure a robust rehabilitation workforce that would improve access to care for patients. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients.

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[4] ARC-PA. Accreditation Standards for PA Education. Fifth Edition. 2024.
[5] Centers for Medicare & Medicaid Services. Pub 100-02 Medicare Benefit Policy, Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018. January 25, 2019.

AAPA recommendation:

- Work with the administration to modify 42 CFR § 412.29 and 42 CFR § 412.622 to authorize PAs to provide all required face-to-face visits.
- Work with the administration to modify 42 CFR § 412.622 to authorize PAs to complete the plan of care.

Inpatient Psychiatric Facilities

PAs perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans; and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists. In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral/mental health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs are integral members of the healthcare team, providing comprehensive care across various medical settings, including psychiatric facilities. However, the existing prohibition on PAs certifying and recertifying the need for inpatient psychiatric care presents a significant barrier to patient access and continuity of care. Allowing PAs to certify and recertify the need for inpatient psychiatric services would enhance patient access to timely care, reduce administrative burdens, and promote continuity of care, especially in rural and underserved areas where psychiatric services may be more difficult to access. This change will remove outdated barriers and support the evolving role of PAs in providing high-quality psychiatric care.

AAPA recommendation:

- Amend 42 U.S.C. 1395f to explicitly authorize PAs to certify and recertify inpatient psychiatric services.

Long Term Staffing Rule
AAPA acknowledges the advantages of minimal staffing standards. However, we also have concerns about the potential burden on facilities, as well as patients and their families, of meeting the minimum staffing standards that were finalized. A recent review conducted by the Kaiser Family Foundation (KFF), found that only 19% of nursing facilities currently meet all three staffing minimums required in the final rule.[6] According to KFF, the new requirements would also hit some states much harder than others in terms of the need for change/increase in staffing. While these staffing changes may be desirable, the cost of increasing staffing at covered facilities may create a financial barrier to care

AAPA recommendation:

- CMS should set the minimum staffing hours for long-term care facilities at a level, and with an implementation timeline, that will meet appropriate patient safety requirements without also creating new financial barriers to care for patients.

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.

[6] Kaiser Family Foundation. A Closer Look at the Final Nursing Facility Rule and Which Facilities Might Meet New Staffing Requirements. 2024.