Top Ten Federal Laws & Regulations Imposing Unnecessary Barriers to Medical Care Provided by PAs

PAs (physician assistants) provide high quality, cost effective medical care in virtually all health settings and in every medical and surgical specialty. PAs are one of three healthcare professionals, including physicians and nurse practitioners (NPs), who provide primary medical care. Studies have shown the quality of care provided by PAs is comparable to that of physicians, PAs enhance care coordination, and practices relying on PAs are more cost-effective than those without PAs. Also, PAs are proven to create access, elevate health outcomes, and increase patient satisfaction. In light of current and increasing healthcare provider shortages, it is critical PAs are better utilized to ensure patients have timely access to care.

Despite the increasing reliance on PAs by the nation's healthcare delivery system, nonsensical and antiquated barriers continue to exist in federal laws and regulations that impede access to medical care provided by PAs. This is particularly true within Medicare. The following are some of the most egregious federal barriers that prevent PAs from practicing medicine at the level accorded by their education and training:

1. Hospice: Medicare beneficiaries may rely on PAs as their principal healthcare provider. But, Medicare does not authorize PAs to certify the need for hospice care or provide or manage hospice care. This omission creates roadblocks to continuous, clinically appropriate care for patients (and their families) at a time when they are most vulnerable.

2. Home Health: PAs are able to provide home healthcare for their patients who are on Medicare, but they are not allowed to order home healthcare or manage the patient's home healthcare plan. A physician, who may have no prior experience with the patient, is required to certify (and recertify) the need for home healthcare and the Medicare patient's care plan, adding unnecessary steps and costs to the system.

3. Cardiac and Pulmonary Rehabilitation: PAs routinely care for patients who have cardiovascular or pulmonary diseases. Yet, only physicians may supervise cardiac and pulmonary rehabilitation programs under Medicare. Cardiac and pulmonary rehabilitation is proven to improve health outcomes for patients who have survived a heart attack or have chronic obstructive pulmonary disease (COPD), but it remains underutilized, especially in rural or medically underserved areas. Allowing PAs to direct and supervise this type of care would provide access to patients who might otherwise not be able to receive it.

4. Reimbursement and Transparency*:* PAs are the only health professionals who are restricted from directly receiving payment for the services they deliver to Medicare beneficiaries. This restriction limits the full utilization of PAs in the healthcare system. In addition, certain Medicare billing policies obscure transparent tracking of the volume and quality of medical and surgical services provided by PAs through Medicare. To realize the potential of a patient-centered value-driven system, we need to improve transparency and remove barriers that limit the ability to attribute patient care quality and outcomes to the health professionals that actually deliver the care.

5. Physician Co-signatures: Medicare requires a physician co-signature for certain orders and patient care services provided by PAs including home healthcare plans and inpatient hospital admission orders. This requirement imposes unnecessary paperwork on physicians who may not be familiar with the patient, obfuscates accountability of care, causes delays, and adds unnecessary steps and cost to the Medicare program. As a result, this outdated requirement should be removed.

6. Federal Workers' Compensation: All state workers' compensation programs cover care provided by PAs. However, the Federal Employees' Compensation Act (FECA) has not been updated in over 40 years and will not permit PAs to diagnose and treat federal employees who are injured on the job. The outdated FECA law results in reduced access to care for federal employees who rely on PAs as their principal healthcare professional, as well as federal workers who reside in medically underserved communities where a PA may be the only healthcare professional available. Additionally, the outdated law adds unnecessary costs to the FECA program as federal workers are advised to seek care through a hospital emergency department rather than to receive medical services through a medical practice where a PA is the sole onsite practitioner.

7. Diabetic Shoes: PAs diagnose and treat illnesses, manage complex medical care, prescribe medications in all states, and assist in surgery – but, regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) do not allow PAs to order diabetic shoes. With the aging U.S. population and prevalence of diabetes, it is absurd a PA can manage a patient's diabetes and other complex chronic conditions, but is not permitted to order diabetic shoes.

8. PACE: CMS regulations exclude PAs from being an employee or contracted provider in the Program of All-inclusive Care for the Elderly (PACE), a Medicare and Medicaid program designed to help patients meet their healthcare needs in the community instead of going to a nursing home or other inpatient facility. CMS has also denied state waivers to allow PAs to provide medical care through PACE – despite the fact PAs provide medical care to Medicare and Medicaid beneficiaries, provide complex, chronic care management and manage patient panels across the nation. (NOTE: CMS published a proposed rule August 16, 2016, to add PAs to the definition of primary care provider for the PACE program.)

9. Graduate Medical Education (GME): PAs are integral to the nation's healthcare delivery system, but GME funds are not used to support PA education. GME funding should be extended to support the education of PAs in hospital settings, as well as outpatient community settings providing primary medical care. By excluding PAs, GME currently creates educational and employment disadvantages for the PA profession. Modernizing GME to support PA education would extend equitable treatment across healthcare professions, ultimately benefitting patient care.

10. Medicaid EHR Incentive: The HITECH Act, contained in the 2009 stimulus bill, did not extend the Medicaid electronic health record (EHR) incentive payment to PAs in the same way it did for physicians and NPs. As a result, Medicaid patients receiving medical care from PAs do not realize the same benefits from EHRs as do patients seen by other practitioners. Additionally, cost-efficient medical practices that utilize PAs are penalized by the ineligibility to receive the EHR incentive. The law creates an inherent disincentive for community health centers and other medical practices that serve a large number of Medicaid beneficiaries to employ PAs.

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