November 29, 2019

The Honorable Representative Danny Davis
The Honorable Representative Terri Sewell
The Honorable Representative Brad Wenstrup
The Honorable Representative Jodey Arrington
c/o House Committee on Ways and Means at Rural_Urban@mail.house.gov

RE: Comments for Ways and Means Committee Rural and Underserved Communities Health Task Force

Dear Representatives Davis, Sewell, Wenstrup, and Arrington,

On behalf of the more than 131,000 PAs (physician assistants) throughout the United States, the American Academy of PAs (AAPA) appreciates the opportunity to provide comments to the Rural and Underserved Communities Health Task Force of the House Committee on Ways and Means. AAPA supports policies to help address healthcare challenges faced by Americans living in rural and underserved communities. For over 50 years PAs have been providing high-quality, cost-effective healthcare services to patients. However, several barriers remain at the federal level 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 and underserved communities suffering from a dire shortage of qualified healthcare professionals. The PA profession is projected to increase 31% in the next decade, and the number of PAs practicing in primary care is expected to increase 39%. [1,2] In 2017, 21% of Medicare beneficiaries in rural areas reported seeing a PA or NP for all or most of their primary care (versus 16% for the nation as a whole). [3]

Below are responses to questions included in the task force's RFI. AAPA encourages the task force to consider solutions to harness the high-quality, cost-effective care provided by the growing PA workforce in rural and medically underserved communities to help address these challenges. While many of the solutions that are likely to be recommended to the task force in questions one through nine will work best when our healthcare system effectively uses the PA workforce do deliver high-quality, cost effective health care, the bulk of the proposal AAPA has been focusing on to improve the Medicare program are programmatic changes that we discuss in relation to question ten.

[1] BLS, "Occupational Outlook Handbook," September 4, 2019
[2] UnitedHealthGroup, "Addressing the Nation's Primary Care Shortage: Advanced Practice Clinicians and Innovative Care Delivery Models," September 2018.
[3] MedPAC, "Report to the Congress: Medicare Payment Policy," March 2019.

Responses to Questions in the RFI

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

> Inadequate healthcare resources (limited health professionals, few or no specialists, limited access to primary care, limited access to rehab services, closing of hospitals, lack of broadband for telemedicine, few home health aides, and lack of transportation) hinder access to care and can disrupt continuity of care. The patient population in rural and underserved areas also tend to be more advanced in age and sicker with more comorbidities than the population at large. Unfortunately, social determinants of health continue to be a major factor in patient health and health outcomes.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

> Congress should consider promoting better coordination among Medicare (both fee-for-service and Medicare Advantage), Medicaid, and state and local programs to improve access to critical social services, housing and substance use disorder (SUD) treatment. This coordination and needed resources from federal, state, and local governments could help communities better address healthcare challenges.
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> AAPA supports expanding the use of telehealth and remote patient monitoring. These services are key to engaging patients and caregivers in better care management, especially for patients with chronic conditions and are essential tools in the management of medical and behavioral conditions. In rural and underserved communities, where a PA may be the sole healthcare provider available, attention must be directed to the coordination and efficient utilization of all available resources, including primary medical care providers, specialists, rural health clinics and rural hospitals. Telemedicine and remote monitoring will be necessary in linking to other parts of the state or region with greater healthcare resources and for assisting the patient and caregiver to manage care at home.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

> Greater access to telehealth services in rural and underserved areas is limited due to complexity and regulatory barriers associated with providers and patients who are in different regulatory jurisdictions. Federal policies should promote interstate compacts or other concepts that authorize physicians, PAs, and APRNs to deliver telemedicine across state lines.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

AAPA encourages the task force to take a look at health professions that are currently more likely to practice in rural and underserved areas (especially in primary care) and strengthen or design more programs to encourage rural practice (e.g., making the 10% HPSA bonus payment available to PAs and APRNs). PAs are more likely than physicians to deliver care in rural communities. For PAs who work in rural communities 39% practice in primary care.[4]

AAPA would encourage Congress to consider funding under or similar to the Medicare GME program to include support for PA graduate training that could be used to pay preceptors as an incentive to train PA students. Some PA programs can choose not to fill their available enrollment slots because they are concerned about finding enough preceptors to allow all their students to graduate. If a portion of this funding was used to fund PA preceptors in rural and underserved areas, PAs who were to train in rural communities and underserved areas would be more likely to come back to practice in such areas after graduation

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Oral health is a vital component of preventive medicine and essential to general health and quality of life across the life span of patients. AAPA has led an oral health care initiative over several years which emphasizes the value of integrating oral health screening into primary care. The initiative has focused on providing education and training to equip PAs with such skills and strategies needed to accomplish these goals. AAPA has found that greater education for primary care providers on the importance of oral health screening can help improve patient awareness and better connect patients to oral healthcare providers

Oral health is often taken for granted and AAPA applauds efforts for the Medicare program to place greater emphasis on addressing oral health care needs and expanding access to such services. PAs are dedicated to helping patients improve oral health and delivering patient education which can have a long-lasting impact on patients' health and well-being.

AAPA encourages payers of behavioral health services to recognize that health professionals who deliver primary care are qualified providers of some basic mental/behavioral healthcare services. While PAs are not a traditional mental health provider specialty group, PAs working with psychiatrists, are trained to deliver mental health specialty services. Many behavioral health payers do not recognize these PAs as eligible to participate in their networks.

[4] AAPA, "PAs in Rural Locations Ready to Meet Primary Care Needs," June 12, 2018.

The Comprehensive Addiction and Recovery Act of 2016 (CARA) helped address the gap in clinicians offering addiction treatment by empowering eligible PAs and nurse practitioners to become qualified prescribers of buprenorphine to treat opioid use disorder (OUD). A recent study found that in the one-year period following enactment of this change, the number of buprenorphine prescribers increased by 12 percent and that PAs and nurse practitioners made up nearly one-fifth of all buprenorphine prescribers.[5] Expanding access to care by ensuring PAs and nurse practitioners are able to practice to the top of their education, training, and licenses will increase access to quality care.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

AAPA encourages increased transparency within the Medicare program by better tracking the health professionals in rural communities. Medicare billing mechanisms such as "incident to" hide the ability to count/recognize PAs in the billing/claims process and make it difficult for state and federal governments to know which health professionals are delivering care in rural and underserved communities.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

Modernize the Medicare program. PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems, yet outdated Medicare policy hinders the ability of Medicare patients to receive medically necessary care from PAs in certain cases. These barriers can lead to a lack of continuity in care, unnecessary care delays, and in some cases the escalation of a condition and provision of more costly care. This is especially true in rural and underserved communities where the PA is often the patient's primary care provider.

- **Authorize PAs to receive direct payment:** PAs are the only health professionals authorized to bill Medicare for their services who can't receive direct payment for those services. This inability to be directly paid often increases administrative burden and necessitates complex billing arrangements. This restriction can limit the flexibility of PAs to work in new and evolving practice and care models. This restriction is particularly burdensome in rural areas, where PAs may be hindered in serving the community due to the lack of direct payment. For example, PAs who own rural health clinics (RHC) are unable to receive direct payment for diagnostic services excluded from the RHC bundle but mandated to be offered by Medicare, forcing these PAs to provide the services without payment. AAPA

[5] Health Affairs, "The Effects Of The Comprehensive Addiction And Recovery Act Of 2016 On Nurse Practitioner And Physician Assistant Buprenorphine Prescribing In Medicaid," November 6, 2019.

requests statutory language to authorize PAs to receive direct payment from Medicare. (See: H.R. 1052 / S. 596). More information.

- **Authorize PAs and NPs to order home health.** PAs and NPs are currently unable to order home health services for Medicare patients, even though they can order home health services for non-Medicare patients. The lack of authorization under the Medicare program disrupts continuity of care and may result in Medicare beneficiaries experiencing a delay or denial in accessing home healthcare. Ensuring PAs are recognized to order home healthcare will increase access and promote continuity of care, particularly in rural and other medically underserved communities where a PA may be the only healthcare professional on site. Additionally, the ability of PAs to conduct the required face-to-face initial home health visit promises greater efficiency and reduced costs. (See: H.R. 2150 / S. 296). More information.

- **Authorize PAs and NPs to order diabetic shoes:** PAs serve as primary care providers for Medicare patients suffering from diabetes and routinely prescribe insulin, manage complex conditions, and order required medical equipment. While PAs are authorized to order DME, outdated Medicare statute excludes diabetic shoes and requires a physician to certify the need. This restriction results in a PA's patient having to schedule an additional visit with a physician to get the shoe order, an inconvenience for the patient that delays care adds an unnecessary expense. With the aging population and increasing prevalence of diabetes – particularly in rural America – authorizing PAs to certify and order diabetic shoes is necessary to remove barriers to care and allow PAs to practice to the top of their license. (See: H.R. 808 / S. 237). More information.

- **Assignment of patients treated by a PA or NP to Accountable Care Organizations (ACOs).** PAs and NPs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned to an ACO as beneficiaries unless patients undertake an additional administrative process to name the PA as their ACO professional. Removing this barrier will enable Medicare beneficiaries who receive their primary care from PAs and NPs to be assigned to MSSP ACOs without arbitrarily requiring the patient to see a physician. It also will encourage ACO formation by helping healthcare providers attain enough beneficiaries to participate. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages, also allowing patients in rural areas to benefit from innovation in our healthcare delivery system. (See: H.R. 900). More information.

Support PA workforce programs. While discretionary federal funding under Title VII of the Public Health Service Act has made an important contribution to educating the next generation of health professionals, the increased demand for primary care services illustrates the need for more to be done. AAPA recommends that policymakers explore how programs such as Graduate Medical Education funding through Medicare may be adapted to provide additional training opportunities to providers such as PAs who are critical to meeting the healthcare needs of rural America.

Thank you for the opportunity to provide feedback. AAPA welcomes further discussion regarding our comments and efforts to improve access to healthcare services in rural and underserved areas. For any question you may have in relation to our comments, please do not hesitate to contact Tate Heuer, AAPA Vice President of Federal Advocacy, at (571) 319-4338 or theuer@aapa.org.