



Physician Assistants: Modernize Laws to Improve Rural Access

*Authors: Roger Wells, PA-C Megan Cody, MPH Robert Alpino, MIA
Melissa Van Dyne Ross Abbott BS. Nikki King, BA, MHSA*

I. Executive Summary

Physician Assistants (“PAs”) are one of three professions providing primary care in the United States, along with physicians and advanced practice registered nurses. The National Rural Health Association (NRHA) recognizes that, despite 50 years of high-quality cost-effective practice, there remain state and federal laws and regulations that prevent PAs from practicing to the fullest extent of their education and experience. Likewise, new and emerging models of care sometimes fail to fully recognize PAs, diminishing the value they could bring to rural patients and communities that are currently suffering from a dire shortage of qualified medical care.

As health care evolves into a system of vertical and horizontal integration with new focus on team-based care, PAs—working at the top of their licenses—will be indispensable providers in rural areas. Modernizing of regulations restricting practice privileges, mental health laws and payer policies that unnecessarily restrict PA practice will increase PA value to employers and enable PAs to more efficiently contribute to ending the shortage of health care professionals accessible to rural patients and communities.

II. Introduction

Analysts’ predictions of physician workforce shortages paint a dire picture for rural America. For decades, rural communities have fought to maintain health care services. Even recent federal efforts to improve access to care by improving insurance coverage did not get to the heart of the rural access issue—a shortage of providers.

The number of physicians practicing in rural areas has been steadily declining for decades. I While the supply of doctors in rural areas have drained into more urban settings, the rural populations they’ve left behind have become increasing less healthyii and less wealthyiii than their urban counterparts. This has created an increasing demand for medical care and a diminished ability to pay for it. Supply of medical care has decreased and demand for that care has increased, but much of the population cannot afford medical services at the new equilibrium price point, creating a massive shortage in care. Today, twenty percent of the U.S. population is rural, but only 11 percent of physicians practice in rural settings.¹



Existing federal programs do not do enough to close this physician shortfall. Additional actions must be taken to increase the supply of medical professionals in rural areas as the demand for their services is projected to increase in the future. Estimates predict that America's rural population will continue to grow in both age and number in the coming years, further widening the gap between the amount of providers and the demand for services.

PAs are one of three professions providing primary care in the United States, along with physicians and advanced practice registered nurses. Despite 50 years of high-quality, cost-effective practice, there are still state and federal laws and regulations that prevent PAs from practicing to the fullest extent of their education and experience. Likewise, new and emerging models of care sometimes fail to fully recognize PA contributions, diminishing the value they could bring to rural patients and communities. Fifteen percent of PAs already practice in rural areas, positioning them to make an immediate and substantial impact on the supply of care if these regulations can be lightened.² As healthcare evolves into a system of vertical and horizontal integration with a new focus on team-based care PAs working at the top of their licenses will be indispensable providers in rural areas.

III. PA Education, Certification, and Licensure

A large, well-qualified applicant pool allows PA programs to be very selective. Typical PA program applicants hold a bachelor's degree and have completed courses in the basic sciences and behavioral sciences as prerequisites to entering a program.ⁱⁱⁱ This is analogous to the premedical studies required of medical students.

Comprehensive master's degree programs provide PAs with a broad, generalist medical education. Programs typically last 27 months and employ an intensive curriculum modeled on medical school.⁶ The classroom phase covers basic medical sciences, including anatomy, physiology, pharmacology, physical diagnosis, behavioral sciences, and medical ethics. 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, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry. PA students complete at least 2,000 hours of supervised clinical practice by the time they graduate.⁶

After graduation, PAs must pass a national certifying exam and obtain a state license. To maintain certification, PAs must complete 100 hours of continuing medical education (CME) every two years and must pass a national recertification exam every 10 years.⁷

IV. PA Scope of Practice



Their broad, generalist medical education prepares PAs to take medical histories, perform physical examinations, order and interpret laboratory tests, diagnose illness, develop and manage treatment plans for their patients, prescribe medications, and assist in surgery.⁸ In rural practices, PAs are likely to take call; provide home, nursing home, and hospital visits; provide direct emergency and urgent care services; perform office procedures; and provide after-hours telephone and internet/email consults.^{ix}

State laws that include a broad scope of practice and allow specifics for each PA to be decided at the practice level are best for patients and providers. Studies show that the quality of care provided by PAs remains high when PA scope of practice is determined at the practice level by the collaborating physician (s).^{5,6,7}

It has been demonstrated when State Laws which include a broad scope of practice and allow the specific duties and activities of specific PA to be determined by the collaborating physician within the collaborating physician's capabilities and PA abilities are best for the patients, providers and community. The scope of practice is then determined by the local practice level and the needs of the community and the local providers. This provides variance for specific privileges, years of experience, advanced education and local needs as Rural environments are widely variable and local needs are widely inconsistent. In some rural communities, a PA is the only provider. Unnecessary restrictions increase costs, burden physicians and PAs, make recruiting physicians more difficult, and reduce patient access to care.

V. PA Workforce

The shortage of primary care physicians is expected to exceed 124,000 by 2025, while the PA profession has doubled every decade since the 1980s, reaching 115,500 in 2017.¹³ Fifteen percent of PAs in clinical practice (17,000 PAs) practice in rural or frontier counties.¹⁴ Studies in Iowa, Texas, California, and Washington state have shown a higher proportion of PAs practice in rural areas than the percentages of other primary care providers.^{15,16,17} The median age of certified PAs is 38 and the mean years since graduation is 10.6, indicating that the PA retirement rate will likely remain far less than the rate of production of new PAs for many years to come. The PA profession continues to be recognized as one of the most desirable professions in the U.S. and has top ratings for job market outlook which attracts a large quantity of high quality program applicants.^{18,19,20} As the PA profession grows, incentives are needed to ensure that adequate numbers of PAs are available, that laws allow providers to work at the top of their education and experience, and practice laws must consider the needs of rural communities with inadequate access to medical care.

VI. Barriers to Optimal Team Practice

There are many well-known factors impacting rural health care—provider shortage and maldistribution, aging of the workforce, long hours, lower pay than urban or specialty



providers, professional isolation, and poor infrastructure such as schools, lack of broadband internet, fewer social opportunities and other issues around spouses' and children's needs. These affect every type of rural provider.

For PAs, there is an additional burden of outdated state and federal laws. For example:

- Medicare does not allow PAs to certify the need for hospice care or to provide or manage it, creating an obvious continuity issue for rural patients.
- PAs are not allowed to order or certify the need for home health services.
- PAs are the only professionals who are restricted from directly receiving payment for the services they deliver to Medicare beneficiaries. This restriction limits the flexibility of PAs to participate in various employment arrangements and obscures the volume and quality of services PAs provide.
- Medicare requires a physician co-signature for certain orders and services provided by PAs including inpatient hospital admission orders and hospital discharge summaries. This is a burden on physicians, obscures accountability, causes delays, and adds unnecessary steps and costs.
- Although state workers' compensation programs in all fifty states cover care provided by PAs, 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.
- PAs diagnose and treat illnesses, manage complex medical care, prescribe medications in all states, and assist in surgery—but Medicare rules do not allow PAs to order diabetic shoes.
- Medicare law requires PAs to practice "under the supervision" of a physician. This language inhibits PA inclusion in team-based care innovations.

A cost analysis conducted in Alabama in 2015 found that even modest improvements in restrictive Alabama PA and NP laws would result in a net savings of \$729 million over 10 years. "Underutilization of PAs and NPs by restrictive licensure inhibits the cost benefits of increasing the supply of PAs and NPs and reducing the reliance on a stagnant supply of primary care physicians in meeting society's health care needs."²¹

Modernizing laws and policies that unnecessarily restrict PA practice will make PAs more attractive to employers and will enable PA to more efficiently contribute to the health of rural patients and rural communities.

VII. Improved Payment Policies Critical

A lack of transparency in billing and payment for services delivered by PAs obscures the PA contribution to care. Payers who do not enroll PAs but accept "incident to" billing or pay for PA-provided care under a physician's name and National Provider Identifier



("NPI") mask PA contributions to patient care. PA provided services should be identifiable as such and should be measured in the same manner as that of other health care providers.

Greater transparency of data regarding medical care provided by PAs will improve understanding of workforce issues within the health care delivery system and may be achieved by:

- Modernizing Medicare payment practices to reimburse PAs directly for patient care in the same manner as all other Medicare providers.
- Requiring the identification of PAs as the rendering professionals for Medicare services they provide.
- Tracking PAs contributions and involvement in services billed "incident to" physicians as shared visits services that are billed under the physicians' names.
- Encouraging public and private payers to adopt standards of transparency and accountability by identifying PAs when they deliver care to patients. Enrolling and credentialing PAs as rendering providers for tracking purposes will enhance the availability of health care data for meeting quality and outcomes metrics which will lead to improved care.
- Permitting PAs to order and provide hospice and home health care for their patients and to be held directly accountable for that care, thereby eliminating the current practice of requiring physician certification or co-signature for hospice, home health care and hospital admissions.
- Repealing Medicare statutory language requiring that PAs practice "under the supervision of a physician," allowing state law to regulate PA practice.

VIII. Mental Health Coverage Lagging

There is a significant need for mental health services in rural America. While the prevalence of mental illness is similar between rural and urban populations, access is very different. Rural residents travel long distances to access mental health care and face a chronic shortage of mental health professionals. With few provider choices, the stigma of receiving care is heightened, creating another barrier.²²

There are about 1,000 PAs practicing with psychiatrists nationwide. In addition, 14,000 PAs practice primary care in rural and frontier areas, many of whom routinely provide mental healthcare to their patients. Another 2,000 PAs practice rural emergency medicine, seeing many patients with mental healthcare needs.

The greatest hurdle is the need for more providers of mental health services in rural and frontier areas.²³ The most significant barrier to PAs collaborating with psychiatrists is lack of third party payment. While Medicare includes PAs among the health



professionals eligible to furnish outpatient diagnosis and treatment for mental disorders, many private behavioral health companies do not recognize or reimburse PAs.²⁴

IX. Improving Rural Deployment

It is essential to attract and retain health care providers in rural areas if rural residents are to fully benefit from the transformation in health care delivery underway in the U.S. Varied strategies, from recruiting health professions students from rural areas and helping to fund their education to pooling community resources to create attractive recruitment packages, will help to increase the presence of rural providers, including PAs.

There are many federal programs that seek to ensure the availability of medical care to underserved rural communities, including the National Health Service Corps, federally certified Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals, to name a few. It is essential that all federal programs supporting rural health care workforce—existing or yet to come—fully include PAs in their policies.

Scholarships and loan forgiveness programs offered at the state level and by the federal National Health Service Corps (NHSC) are examples of means to attract medical professionals to practice in rural medically underserved areas. 52 % of NHSC participants remain in the rural area in some capacity for up to 15 years after their commitment.²⁵ Other states offer grants and forgiveness loans to new attract students if they participate in a rural location for a designated amount of time based on the forgiveness loan requirement.

A new rural health care infrastructure model, the Community Outpatient Hospital, as proposed in the Save Rural Hospitals Act legislation, would be an innovative delivery model that will ensure emergency access to care for rural patients and which could also provide primary care services through a FQHC. This new model would have a new Medicare payment designation and could provide opportunities for PA employment in areas where traditional rural hospitals may be in jeopardy.

X. Federal Policies and Programs

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, encourages the use of PAs in rural areas in order to realize value and quality improvements. The ACA recognized PAs as a primary health care profession and furthermore provided financial support for the education of rural PAs, initiated temporary Medicare incentives for PA primary care services and integrated PAs into new value-based payment models including Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH).²⁶



Federal programs have been utilized to improve both the supply and the distribution of PAs in the U.S, but are annually vulnerable to reductions in federal budget proposals. Better recognition of these programs importance during the budget appropriations process could impact the number of PAs practicing in rural areas. Programs and initiatives include:

- Title VII of the Public Health Service Act funding through the federal Health Resources and Services Administration (HRSA)
- Area Health Education Centers (AHEC)
- National Health Service Corps (NHSC)
- Medicare's Critical Access Hospital Flex program
- Rural Health Clinics Act (RHC)

The programs are part of the solution to the problem of appropriate distribution of health care providers. For example, from 1990 to 2009, Title VII funded PA grads were 47% more likely to work in rural health clinics.²⁷

In addition to burdensome laws, a lack of transparency in billing and payment for services delivered by PAs obscures the PA contribution to care. Payers who do not enroll PAs but accept "incident to" billing or pay for PA-provided care under a physician's name and NPI mask PA contributions to patient care. PA-provided services should be identifiable as such and should be measured in the same manner as that of other health care providers. Arguably, the greatest hurdle is the need for more providers of mental health services in rural and frontier areas. The most significant barrier to PAs collaborating with psychiatrists is lack of third party payment. While Medicare includes PAs among the health professionals eligible to furnish outpatient diagnosis and treatment for mental disorders, many private behavioral health companies do not recognize or reimburse PAs.

Encouragingly, Congress has recently removed one such unnecessary barrier to PAs providing care. The opioid abuse epidemic across the U.S. has severely impacted rural America. Until recently PAs could only legally prescribe buprenorphine for pain management but could not prescribe it for treatment of opioid addiction. Since the opioid abuse epidemic has hit rural America disproportionately hard, that regulation had been particularly problematic in rural areas that only had PA providers available. In July 2016, however, the passage of the Comprehensive Addiction and Recovery Act (P.L. 114-198) legislation changed federal law to provide PAs the legal authority to prescribe buprenorphine as an opioid addiction treatment.

A disproportionately higher number of Medicare beneficiaries in rural areas vs. urban areas makes it even more important to take into account reimbursement levels and particularly differences in rural versus urban actual costs for services in the move to new value-based payment models.



XI. State Policies and Programs

State legislatures across the country modernize PA laws and regulations every year. Key areas of modernization include laws governing efficient collaboration between PAs and physicians, patient access to PAs, and enrollment of PAs as providers in state Medicaid programs.

Despite advances, improvements can still be made. Rural patients would particularly benefit from updated laws allowing practices to decide an individual PA's scope; eliminate legal requirements for PAs to have a specific relationship with a physician in order to practice and leave decisions about the necessary level of collaboration with a physician up to each practice.

All states have laws and regulations that explicitly authorize physicians to collaborate with PAs through electronic communication, but some states couple that authorization with requirements that a physician visit at particular intervals or be within a certain travel time or distance. Statutes and regulations that impose these types of restrictions interfere with patient access and provider availability.

For example, in Missouri, until 2013, the state required a physician to be onsite 66 percent of the time a PA spent with patients and had to otherwise be within 30 miles. The 2013 law reduced those requirements so that a physician must be onsite for a half-day every two weeks and must otherwise be within 50 miles. While this change is a laudable improvement, the law still imposes an unnecessary burden on physicians and PAs in a state where 97 percent of the land and 30 percent of the residents are rural.²⁸

In addition to removing barriers from PA practice laws, each state must define the regulatory agency responsible for implementation of those laws. The preferable regulatory structure is a PA licensing board composed of a majority of PA, and other members who are knowledgeable about PA education, certification, and practice. If regulation is administered by a multidisciplinary healing arts or medical board, the full voting membership must include PAs and physicians who practice with PAs.²⁹

Team practice—with the ability to make referrals or collaborate and consult with physicians—is central to PA practice. However, state laws that require a PA to have a specific association with a designated physician or group of physicians limits both PAs and physicians, which are constraints rural communities cannot afford.

XII. Summary



Providing adequate health care services in rural America is a complex challenge. Workforce analyses and recommendations should include every type of medical professional who can serve rural communities. Increased numbers and better distribution of PAs in rural areas can be achieved if practice barriers are removed and reimbursement and incentives payments are appropriate. Many factors affect whether or not providers choose rural practice. The NRHA provides a neutral, collaborative setting where different interest groups can come together to discuss solutions to the challenges of delivering health care services in rural settings. NRHA's goal in the U.S. health care delivery system of the future is to ensure access to quality health care for all rural residents. To enable PAs to maximize their contribution toward achieving that goal, we offer the following recommendations.

1. National and state workforce policies should ensure adequate supplies of PAs and other providers to improve access to quality care and to avert anticipated provider shortages.
2. All new and emerging care models and payment systems should fully recognize PAs as providers of medical services.
3. Laws and regulations should allow scope of practice details for individual PAs to be decided at the practice level.
4. PAs should be included in programs to recruit and retain rural providers.
5. Regulatory and policy updates are needed to remove barriers to optimal PA practice in rural communities. Public and private agencies and organizations, including NRHA, should work together to ensure that regulatory changes in publicly funded programs have a positive impact and do not adversely affect access to health care in rural areas.
6. Public and private payers should adopt standards of transparency and accountability, credentialing and enrolling PAs so that PA performance can be, and further, PAs should be eligible for direct payment from all public and private payers.
7. Public and private payers should cover mental health care services provided by PAs, which will help to increase access to mental health care for rural patients.
8. Health care workforce development programs should recognize and support PAs.
9. State legislatures and regulatory agencies should modernize PA practice laws by removing barriers to optimal team practice and ensure PA representation on regulatory boards.



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