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STATEMENT BY THE AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS

ON

MEDICARE REIMBURSEMENT OF PHYSICIAN'S ASSISTANT SERVICES*

Dana Vandehet

Mr. Chairman and Members of the Committee:

I am honored to have the privilege to testify before the Subcommittee once again on the need for legislation to permit Medicare (Part B) reimbursement for patient care services rendered by physician's assistants; and more specifically, to discuss HR2504 introduced by Mr. Rostenkowski on January 26, 1977.

I am a graduate of the Duke University Physician's Assistant Program, and am currently employed by the University of Oklahoma as an Assistant Professor in the Department of Family Practice and Community Medicine and Dentistry while serving as Associate Director of the Physician's Associate Program. I have also practiced in a rural primary care clinic while employed by the Mayo Clinic-Mayo Foundation. I have been appointed to many DHEW advisory committees and have served on the Board of the National Commission on Certification of Physician's Assistants.

Myths and Misconceptions Regarding the Physician's Assistant Concept

It has been stated that the development of the physician's assistant profession has at best been haphazard and disjointed, with a resultant lack of

*Presented by Thomas R. Godkins, immediate past President and Chairman, Goals and Priorities Committee, American Academy of Physicians' Assistants, to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, January 28, 1977.

appropriate standards. Contrary to the opinions of the uninformed, the development of this profession has been done methodically with, in every respect, concern for quality. In September, 1975 I testified before this Subcommittee on the development of this emerging profession.[1] Let me state the myths and counter with the facts.

Myth: Tremendous disparity within the educational process of physician's assistants.

Fact: The American Medical Association's Council on Medical Education in conjunction with specialty medical societies, has developed an accreditation mechanism recognized as an accrediting agency by the U.S. Commissioner of Education.[2]

Myth: No mechanism for quality assurance.

Fact: The National Commission on Certification of Physician's Assistants administers an extremely reliable examination developed by the National Board of Medical Examiners.

Myth: Few states recognize physician's assistants.

Fact: Approximately 40 states recognize and regulate the physician's assistant.

Myth: Poor patient acceptance.

Fact: The literature is replete with descriptive information acknowledging excellent patient acceptance of this health care

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[1]"Position Statement on Medicare Reimbursement for Physician Extender Services," presented to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, by Thomas R. Godkins on September 26, 1975.

[2]AMA, "Educational Programs for the Physician's Assistant," AMA Division of Medical Education, Department of Allied Medical Professions and Services.

provider.[3,4]

Myth: Utilization of P.A.s will decrease the quality of care and increase the inappropriate utilization of diagnostic services.

Fact: Physician's assistants render patient care of an acceptable quality as reported by Record, et al., at the Kaiser Foundation Health Services Research Center in Portland, Oregon, Stanhope at the University of Oklahoma, and Ott at the University of Colorado. In addition, there is evidence that the utilization of physician's assistants does not increase the inappropriate use of diagnostic services.[5]

Myth: Physician's assistants increase the risk of malpractice.

Fact: Physician's assistants, by improving the quality and continuity of patient care, reduce the physician's risk of malpractice. Betty Jane Anderson, AMA Assistant General Counsel, has stated, "after looking at ways in which P.A.s perform their services, I feel P.A.s probably hold the potential...as...one of the best malpractice prevention tools...available to physicians."[6]

Myth: Use of physician's assistants will increase the cost of medical care.

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[3]Nelson, Eugene C., et al., "Patient Acceptance of Physician's Assistants," JAMA, 228:1, pp. 63-67, 1974.

[4]Pondy, L. R., et al., "The Study of Patient Acceptance of the Physician's Assistant," Proceedings of the Third Annual Duke Conference on Physician's Assistants, Duke University Medical Center, Durham, North Carolina, 1970.

[5]Record, Jane C., et al., "Cost Effectiveness of Physician's Associates: Kaiser-Permanente Experience," Health Services Research Center, Portland, Oregon, 1975.

[6]Ryser, J., "P.A. Seen as Asset in Liability Crisis," American Medical News, American Medical Association, Chicago, Illinois, April 26, 1976.

Fact: Peterson, et al., at the Baylor College of Medicine, reported an 85% reduction in hospitalizations utilizing P.A.s in an ambulatory clinic resulting in a cost savings well in excess of $27,000.00 (for one year).[7] This data was substantiated by Runyan who also reported cost savings through a reduction in the need for hospitalizations.[8] Most importantly, Record's studies on cost effectiveness of physician's assistants revealed P.A. productivity per clinic work hour compared favorably with physician output rates (for the same office visit categories) and that significant cost savings can be instituted with the utilization of these practitioners.[9]

The development of this profession has not been haphazard and disjointed, but carefully planned by individuals on the cutting edge of medical education.

Congressional Support

The Congress has fostered the growth and development of this profession. Federal funds to support education with subsequent research on the utilization of physician's assistants has been substantial. A reasonable estimate of total federal expenditures for physician's assistant education and research is approximately $47,224,919.00 in the past decade (exclusive of military expenditures).[10]

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[7]Peterson, R. L., et al., "Cost Benefits of P.A. Staffed Ambulatory Clinics," unpublished data reported by the Physician's Assistant Program, Baylor College of Medicine, Houston, Texas, 1976.

[8]Runyan, J. W., "The Memphis Chronic Disease Program," JAMA, 231:3, pp. 264-267, 1975.

[9]Record, op. cit.

[10]Academy estimates following personal communication with Susan Horowitz, Physician Extender Work Group, Dept. of Health, Education and Welfare, Public Health Service, Health Resources Administration, February 23, 1977.

In my testimony before this Subcommittee on September 15, 1976 I reviewed the Medicare problem and the legislation submitted before the 94th Congress.[11] The 95th Congress has once again seen the submission of multiple pieces of legislation including: HR2504 by the Chairman of this Subcommittee, HR1955 by Mr. Duncan, HR3635 by Mr. Broyhill, S484 by Mr. Pearson, and S708 recently introduced by Mr. Clark and Mr. Leahy. All of these bills address the inequity in Medicare Part B which does not allow reimbursement for the patient care services provided by physician's assistants.

The Dichotomy and the Barrier

Title XVIII of the Social Security Act does not adequately authorize Medicare Part B reimbursement for physician's assistant services /Section 1861(s)(2)(A)/. According to the Social Security Administration, the performance by a physician's assistant of services which traditionally have been reserved to physicians can not be covered under Medicare Part B even though all other "incident-to" requirements are met. This policy of non-reimbursement is the impediment to the optimum utilization of physician's assistants. In 1972 Congress intended to bring resolution to the problem through passage of HR1 (PL92-603, Sec. 222) which gave the Social Security Administration responsibility for the implementation of a research study evaluating physician extender reimbursement. This study was intended to be completed in five years, but unfortunately the final outcomes will not be reported until 1979. To add insult to injury, the Bureau of Health Insurance has conducted

[11] "Medicare Reimbursement of Physician and Physician Extender Services," presented to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives by Thomas R. Godkins, September 15, 1976.

secretive audits using extremely weak methodology, harassing employing physicians who are attempting to improve patient care and its access. These subversive audits point once again to the need for Congressional intervention to amend the Social Security Act to allow the appropriate utilization of physician's assistants.

The previous administration seems to have had a difficult time dealing with the Medicare problem. I would like to introduce into testimony a copy of an article which appeared in the Washington Post entitled, "Rural Health Care in Appalachia" which ex-Secretary Matthews sent to then Assistant Secretary Theodore Cooper asking, "Is this correct? If so, are we doing the right thing?"[12] The article cited the fact that Medicare regulations prevent clinics from being reimbursed for the services rendered by physician's assistants. I would also like to introduce Assistant Secretary Cooper's response to ex-Secretary Matthews dated May 20, 1976 which in part states, "...I do not believe that we are doing the right thing... provisions like this inhibit the development of alternative forms of health care delivery, which can provide needed additional access and be of high quality at an affordable cost...we are presently studying various legislative and regulatory changes."[13] President Carter and his administration seem sincerely concerned about bringing resolution to this problem and, in his current budget, has requested monies for the continued funding of P.A. programs and to provide for Medicare Part B reimbursement of physician extender services.[14]

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[12]Editorial, "Rural Health Care in Appalachia," Washington Post, April 24, 1976.

[13]Cooper, Theodore, memorandum to the Secretary entitled, "Your Inquiry Re the Medicare Regulation Which Prevents Reimbursement to Clinics for Services Unless a Physician is Physically Present -- Information," Office of the Assistant Secretary for Health, Department of Health, Education and Welfare, May 20, 1976.

[14]"Ceiling on Nation's Hospital Costs to be Sought in Carter Legislation," Washington Star, p. 5, February 22, 1977.

Finally, the Comptroller General of the United States in his report to the Congress entitled, "Progress and Problems in Training and Use of Assistants to Primary Care Physicians," concluded:

"1) physician extenders have generally improved the accessibility and quality of medical care provided in their employer's practices; and

2) the issue of reimbursing for physician extender services needs to be resolved."[15]

HR2504; Recommendations

In exploring alternative methods and amounts of reimbursement, individuals from the Academy have met with representatives of the American Academy of Family Physicians (AAFP), the American Medical Association (AMA), and the American Nurses Association (ANA). Both the AAFP and the AMA have taken the position that physicians should be reimbursed for patient care services provided by physician's assistants at usual and customary rates of Medicare reimbursement. They oppose suggestions promoting the concept of reduced rates of reimbursement for all physician's assistants. Representatives from these organizations, and our Academy, believe discriminating rates of reimbursement would: 1) increase the administrative costs in implementing the program; 2) connotate "second class medicine" to the consumer (who equates quality with cost); 3) serve as a negative incentive for physician employment of P.A. graduates; and 4) not adequately improve access to care for all Americans. Likewise, the American Nurses Association seems supportive

[15]"Progress and Problems in Training and Use of Assistants to Primary Care Physicians," Department of Health, Education and Welfare, Office of the Comptroller General, April 8, 1975.

of appropriate legislation which adequately defines the nurse practitioner and the qualifications of these professionals for Medicare reimbursement.

I would like to commend the Congress for introducing substantive legislation: HR2504 by Mr. Rostenkowski, HR1955 by Mr. Duncan, and HR3635 by Mr. Broyhill. All three bills reflect Congressional concern over the potential cost impact of physician's assistant reimbursement on the Medicare program. It is important for this Subcommittee not to overlook physician:P.A. differential training costs which is saving the federal government a substantial amount of money. Likewise, physicians are not "buying" a profit (in a monetary sense) but are employing P.A.s to improve the continuity and quality of care as well as give them time to continue their education. Most importantly, relative to HR2504, Dr. Lawrence at the University of Washington (Seattle) estimates that only 31 of 400 practices utilizing physician's assistants and nurse pracititioners in the Pacific Northwest (Washington, Alaska, Oregon, Montana and Idaho) would receive reimbursement under the legislation proposed by Mr. Rostenkowski. [16]

I would like to recommend HR2504 be amended and/or consideration be given toward combining the outstanding components of the legislation submitted in the 95th Congress in the development of a new bill. More specifically, I would like to comment on some of the provisions in HR2504 which warrant further attention:

Proposed: Section 1833, "with respect to rural health clinic services, payment shall be made...on the basis of costs reasonably related to providing such services...";

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[16] Personal communication with David Lawrence, M.D., School of Medicine, University of Washington, Seattle, Washington, February 24, 1977.

Recommend: "with respect to physician's assistant services, payment shall be made to the supervising physician and/or rural health clinics, on behalf of an individual, at the usual and customary rates of reimbursement";

Proposed: Section 1861, "is located in a rural area...designated by the Secretary as...medically underserved...";

Recommend: Deletion with the adoption of language which provides a consistent reimbursement policy whereby Medicare payment is provided for the provision of services regardless of the location.

Proposed: Section 1861, "is not a physician-directed clinic under direct personal supervision";

Recommend: "the activities and patient care services of physician's assistants shall be provided under the responsible supervision of (a) physician(s). Services of a physician's assistant shall include services performed regardless of whether the physician was actually present and regardless of whether the services were performed in the physician's office or at some other site";

Proposed: Section 1861, "physician extender means...a physician's assistant, MEDEX, nurse practitioner, or any other such practitioner who performs, under the supervision of a physician...such services as he is legally authorized to perform in accordance with state law...";

Recommend: The term "physician extender" and "any other such practitioner" be deleted and the terms "physician's assistant" and "nurse practitioner" be substituted. "Physician's assistants be

defined as individuals who have completed an educational program for physician's assistants accredited by the American Medical Association or other recognized accrediting agencies and/or are holders of current valid certificates from the National Commission on Certification of Physician's Assistants"; and the "physician's assistants are recognized as practitioners under the laws of the state in which the services are provided."

I would like to thank Congress for addressing this important problem. Physician's assistants are improving patient access to care and it seems unfair to deny primary care reimbursement to Medicare beneficiaries. Most importantly, Congress has the opportunity to institute a program which has great potential towards reducing the total cost of health care in this country. Thank you for allowing me to testify.

End of Testimony

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