June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510-1008

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, DC 20510-6295

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the more than 100,000 nationally certified physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), we applaud your leadership in establishing the Senate Finance Committee's chronic care working group. AAPA agrees with the Committee's assessment of the prevalence of multiple chronic diseases among Medicare beneficiaries and the enormous cost associated with chronic disease to the Medicare program. We appreciate your request for feedback on the specific policy categories the Committee plans to consider as part of its initiative and we are confident the Committee and working group can develop solutions to improve the way healthcare is delivered and coordinated for Medicare patients with multiple, complex chronic conditions.

PAs' Contribution to Chronic Disease Management and Care Coordination

One of three healthcare professionals, along with physicians and nurse practitioners (NPs), who provide primary medical care, PAs are uniquely flexible in adapting and responding to the evolving needs of the U.S. healthcare system by virtue of comprehensive educational programs that prepare PAs for a career in general medicine and for a team-based approach to providing patient-centered medical care. PAs diagnose illness, develop and manage treatment plans for their patients, help manage their own patient panels, and often serve as Medicare beneficiaries' principal healthcare professional. In rural and other medically-underserved communities, a PA may be the only healthcare professional in the community. The PA profession's team-based approach is well-suited for the patient-centered medical home model of care, as well as other integrated models of care management.

Chronic care management is a key component of a typical PA's practice. Our 2013 AAPA Annual Survey revealed that 64% of PAs provide chronic disease management – and most of these PAs see patients with multiple chronic conditions. Furthermore, PAs provide an important access point in medically underserved areas of the nation. Approximately, 37 percent of PAs work in medically underserved counties in the U.S. On average, 23 percent of patients seen by PAs are enrolled in Medicaid, 14 percent are dual eligible and 16 percent of their patients are uninsured.

PA education and practice emphasize patient education, preventative care and chronic care management. Among the findings related to PAs and chronic disease management associated with the elderly population are:

- High patient satisfaction and better adherence to care plans. Patient assessment of medical providers is critically important because satisfied patients are more likely to follow through with the healthcare professional's recommendations. Patient engagement and adherence are key in the management of complex chronic care. A 2014 Harris Poll survey found of the respondents who had seen a PA, more than 90% trust PAs and more than 90% believe PAs improve both health outcomes and improve the quality of healthcare. A 2006 study published in the Journal of the American Academy of Physician Assistants found that older consumers are satisfied with care provided by PAs.
- PAs are more likely to provide care for those beneficiaries with the most complex chronic conditions. A 2013 study published in Medical Care Research and Review found that primary care panels with PAs (and NPs) have a higher proportion of socially complex cases, suggesting that PAs (and NPs) are more likely to provide care to underserved populations with depression and dementia.
- PAs contribute to lower hospitalization rates. A study published in the Journal of the American Geriatrics Society in 2004 indicated that nursing homes that used PAs had lower hospitalization rates of long-stay residents thereby savings costs and improving patient quality of life.
- PAs contribute to lower severity of illness in critical care management. A 2014 study published by the American College of Chest Surgeons reported that intensive care units using PAs (and NPs) tended to have lower severity of illness and lower use of mechanical ventilation, supporting an increased use of PAs (and NPs) in critical care management, typically part of chronic care management.
- PAs help reduce hospital readmissions rates. A January 2013 article in the Journal of Thoracic and Cardiovascular Surgery concluded that a 30-day hospital readmission rate for patients who underwent cardiac surgery was reduced by 25 percent for patients receiving home visits and medication adjustment by PAs, a key example of chronic care management for cardiac patients.
- PAs play a critical role in patient education on chronic diseases. Published in 2014, a Centers for Disease Control and Prevention review of differences in the delivery of health education to patients with chronic disease by provider type found that PAs (and NPs) provided health education to patients with chronic illness more regularly than did physicians. PAs play a critical role in chronic care management and frequently when patients see specialists; it is the PA that is more likely to provide chronic care management for a patient.

Recommendations to Improve Chronic Care Management in Medicare Programs

Language in H.R. 2, the Medicare Access and CHIP Reauthorization Act ("MACRA") formalized payment for chronic care management under the Medicare fee schedule while also reiterating that PAs, NPs, and physicians are fully authorized to be reimbursed for the delivery of chronic care management. Authorization of and payment for chronic care management is a very positive step in addressing

Medicare beneficiaries with multiple chronic diseases. The Centers for Medicare and Medicaid Services recognizes chronic care management services as one of the critical components of primary care that contributes to better health for individuals, lower costs, and reduced hospital re-admissions using Current Procedural Code 99490. Language in MACRA formalized payment for chronic care management under the Medicare fee schedule while also reiterating that PAs, NPs, and physicians are fully authorized to be reimbursed for the delivery of chronic care management.

AAPA policy supports optimal utilization of primary medical care and an emphasis on health education and promotion and disease prevention; and encourages the use of comparative effectiveness research and evidence-based medicine – all of which are found to be essential in improving health outcomes and lowering the cost of care for patients with multiple chronic conditions.

To build upon the new MACRA requirements, PAs are taking an active role in emerging models of coordinated care delivery. AAPA recommends the Finance Committee look at best practices in chronic care management emerging from Accountable Care Organizations, Patient-Centered Medical Homes, Center for Medicare and Medicaid Innovation (CMMI) grant awards, and the Veterans Health Administration, particularly with respect to:

- alternative payment models
- the role of health education
- patient engagement, particularly the role of monitoring and self-management of the disease.

AAPA is particularly impressed with the outcomes and cost savings resulting from the CMMI Independence at Home demonstration programs. We are concerned, however, that the CMMI demonstration project requires that the teams be led by a physician or NP. This is contrary to language contained in the statute, which says, "PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice…" (Section 3024 (2), P.L. 111-148)

Telemedicine

Telemedicine, including remote monitoring, offers tremendous promise in the management of chronic disease while allowing the patient to continue to live at home. Licensing is a particular challenge for healthcare professionals engaging in telemedicine across state lines. AAPA believes that the licensure system must provide appropriate patient protection and access; however, AAPA opposes geographic restrictions and limitations on the provision of care. AAPA opposes a separate telemedicine license for PAs and supports reciprocal relationships with neighboring states and multistate compacts whereby a license to practice medicine in one state facilitates licensure in other states for the purposes of reducing barriers to individual providers, and patients from use of this means for obtaining healthcare services. AAPA policy supports safeguards in the use of telemedicine for establishing a provider-patient relationship; patient disclosures and consent to treatment; evaluation and treatment of the patient; continuity of care; referrals for emergency services; security of medical records; and patient confidentiality.

Chronic Care Coordination in Rural and Frontier Communities

In some rural and frontier communities, a PA may be the sole healthcare professional available. Policy efforts aimed at managing chronic diseases and reducing the number of preventable hospitalizations among Medicare beneficiaries who live in rural and frontier areas will be particularly challenging. Special 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 key to linking with other parts of the state with greater healthcare resources and for assisting the patient and caregiver to manage care at home.

Options for Empowering Patients

Engagement of patients and their caregivers is critical in managing complex chronic medical care and preventing unnecessary hospitalization. Patients' trust in their healthcare providers, as well as improvements in patient education, are necessary prerequisites in encouraging patient management of the disease. Patients trust PAs, and PAs are more likely to provide health education than physicians. Patients must also be provided tools to manage their disease(s) such as care coordination or case management through home visits and/or telemedicine, access to medical records and remote monitoring.

Utilization of Primary Care Providers and Care Coordination Teams

In managing chronic care, PAs, NPs, physicians, and other healthcare providers must all be permitted to practice to the top of their educational preparation, experience, and license. Care coordination teams should reflect the healthcare needs of the patient and need not be led by a physician. For example, if a patient's primary chronic disease is schizophrenia, it may be more appropriate that the team be led by a behavioral healthcare professional. A primary care provider should be an active participant in every team. For this goal to be realized, Medicare must be updated to reflect the advancements of the PA profession. Laws and regulations must be updates to permit PAs to:

- Provide and manage hospice care
- Order home healthcare
- Supervise cardiac and pulmonary rehabilitation services
- Order diabetic shoes
- Participate in the PACE program.

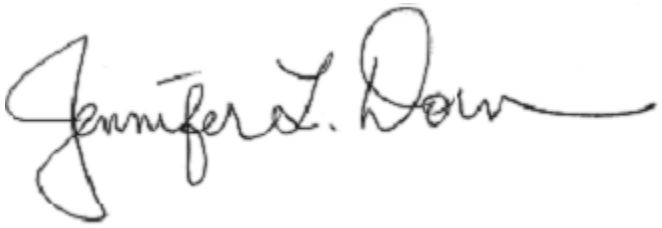
AAPA is taking a lead in engaging PAs and patients in chronic care delivery. For example, AAPA offers continuing medical education (CME) on the best practices in diabetes care through its online *Learning Central* program and through CME sessions throughout the country. AAPA also encourages its membership to become involved in patient registries on diabetes care. Healthcare professional organizations should be encouraged to become actively engaged in chronic care management as well.

Thank you for the opportunity to submit comments to the Senate Finance Committee on the management of complex chronic care. New policy initiatives, utilizing best practices, hold promise in ensuring better health outcomes and lowering the cost of care for the nation's aging population. Should you have any questions or request additional information on AAPA's comments, please do not hesitate

to contact Sandy Harding, AAPA senior director of federal advocacy, at 571-319-4338 or via email at sharding@aapa.org.

AAPA looks forward to being a resource to the Senate Finance Committee as it moves forward with this critically important policy initiative.

Sincerely,



Jennifer L. Dorn
Chief Executive Officer