**To:** **Senate Finance Committee**

**Bill:** **Senate Bill 167 - Physician Assistants - Revisions (Physician Assistant Modernization Act of 2024)**

**Date:** **February 20, 2024**

**Position:** **Favorable**

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The Maryland Academy of Physician Assistants strongly supports *Senate Bill 167- Physician Assistants – Revisions (Physician Assistant Modernization Act).* The bill streamlines the process for physician assistants to be able to enter into and remain in practice.

**Maryland law requires a double-layer review process for physician assistant practice. No other state does.**

Maryland's law requires the Board of Physicians to impose a double-layer review process in determining if a physician assistant (PA) may enter into practice. First, a physician assistant must be licensed and file a delegation agreement with the Board. Then, before performing any "advanced duties", a PA must wait for review and approval by the Board. This process can take 2 to 3 months.

No other state requires this process, and there is a reason. PAs are already legally obligated to practice within their education, training, and experience. West Virginia eliminated the double-layer review requirement for advanced duties 2019, leaving Maryland as the only outlier. Research has demonstrated that removing restrictive laws regarding PA practice does not lead to poor patient outcomes.[i]

The "advanced duties" process is onerous, lengthy, and uncertain. Senate Bill 167 proposes to eliminate this requirement and creates a clearer pathway for PAs to practice.

**Maryland law makes it harder for PAs to practice in primary and community-based settings. Maryland needs PAs in these settings.**

With the double-layer of review for PA practice, it is challenging for any health facility to employ PAs. The double-layer review for PAs means that health facilities and programs:

- Cannot hire PAs with any certainty of what duties they will be able to perform;
- Cannot hire PAs with any certainty of when they will be able to serve patients in their full capacity, as the advanced duties review process can take 2-3 months; and
- Cannot hire PAs with any certainty of when health insurers will reimburse for their services. To provide reimbursable services, a PA must often be recognized as provider (often as part of a "provider panel"). However, the requirement for a double-layer of review creates confusion and uncertainty about reimbursement for PA services.

For community health centers and small private practices, it is particularly challenging to hire and utilize PAs. They simply do not have the administrative bandwidth.

Maryland's statute creates a misaligned system for PA practice. It is easier for PAs to practice in large institutional settings, even though PAs have their roots in primary care. The first educational program for PAs, established at Duke University in 1967, was for the express purpose of expanding access to primary care.

Maryland needs more practitioners in primary care settings. According to the Health Resources and Services Administration, Maryland has a primary care shortage in 19 jurisdictions: Allegany, Anne Arundel, Baltimore City, Baltimore, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Montgomery, Prince George's, Somerset, St. Mary's, and Washington Counties.

**SB 167 delivers a key solution in addressing the health professional shortage. The bill would streamline and update the regulatory process for PA practice.**

Senate Bill 167 modernizes the regulatory framework for PA practice. It eliminates the double-layer review process for PAs to provide "advanced duty" services to their patients. The bill also provides for other key statutory updates: 1) updating the nomenclature to describe the physician-PA relationship as collaborative to reflect how the health care system is actually structured; 2) eliminating the requirement that physicians sign all PA prescriptions as this requirement creates significant barriers to patients obtaining care; and 3) providing more flexibility for PAs to remain in practice when the physicians in their clinical care team retire or move to a new job.

**Please vote favorably for SB 167. The bill removes unnecessary barriers for PAs to serve patients in their communities.**

We ask for a favorable vote. According to the final report of the Commission to Study the Health Care Workforce Crisis in Maryland, Maryland is further behind than other states in addressing health professional shortages. Maryland needs SB 167. If any additional information would be helpful, please contact Robyn Elliott at relliott@policypartners.net.

**Maryland’s Outdated Law on Physician Assistant Practice**

**Consequences for Physician Assistants, Patients, and the Health Care System in Maryland**

*The Maryland Academy of Physician Assistants has compiled these personal stories of physician assistants in Maryland. These stories represent only a small sample of the real-life impact of Maryland’s outdated law on Maryland patients and the health care system.*

1. I have students who live in and have had educational clinical rotations in Maryland. Many of these students find practicing in DC or Virginia is preferable because they have less administrative burden paperwork required for practice. They choose to seek jobs outside of the state.

2. I have worked as a primary care provider in St. Mary’s County Maryland for the past 6 years. I did my training out of state where I was trained in trigger point injections (a minor in office procedure that provides immediate relief for muscle tension and spasm). Upon moving to Southern Maryland and starting practicing, I already had ample clinical experience which did not necessitate prolonged hands-on training with my supervising physician. As such, I immediately stepped into my busy role as a primary care provider. Patients often first seek care by seeing their PCP for things like muscle spasms. I discovered upon starting practice that administering trigger point injections is considered an advanced practice in Maryland and I was suddenly unable to perform this service and provide relief to patients who came into my office. The state requires that my supervising physician personally observe and sign off on a set number of procedures prior to my being able to submit a request for approval of that advanced duty regardless of my prior experience. Because of how busy we are and how few primary care providers we have in our area, my supervising physician and I are seldom in the same location at the same time, making it impossible for us to complete the required number of observations. I have performed hundreds of these in other states and would easily be able to demonstrate my proficiency in one observation. But because of the current requirements, it is impossible for us to meet this requirement. As such, I am forced to refer my patients to an orthopedic or pain management office which necessitates more office visits for the patient, more administrative burden with referrals, and higher cost to the patient due to higher specialist copays.

3. Even though I work as a primary care provider with a full independent patient panel, some insurances refuse to recognize me as my patients’ PCP. This causes significant delays in being able to properly provide referrals to specialists resulting in confusion and frustration on the part of the patient along with delay in care.

4. I work in an FQHC in Baltimore City but am unable to provide needed services like IUDs/contraceptive care despite having training courses available to me on-site due to Advanced Duties restrictions. Creates an unnecessary referral which increases healthcare costs and decreases access to care, some patients are unable to get to specialist appointments.

5. I have personally been unable to work when my SP (supervising physician) left the practice. I was forced to look for another position and not provide medical care to patients for 6 months.

6. Many sites, FQHCs included, preferentially hire NPs because there are no waiting periods, fees, or other restrictions due to supervisory laws. This creates provider shortages in outpatient sites; especially in primary care, and prevents access to care for the rural and inner-city people who need it the most.

7. I can provide quality health care to the marginalized, including LGBTQ, non-English speaking and uninsured patients as well as provide resources. I am a lecturer for Medical/PA/NP programs on LGBTQIA Health disparities and am considered a subject matter expert in Transgender Care for the Child and the Adult.

8. Physician Assistants are highly trained to provide high quality, evidence -based medical care to patients. There are severe barriers to access of care especially to the marginalized population. Patients now have to wait months for appointments for office visits, preventive care and emergency services. In general, other potential ways that PA Laws in Maryland create barriers to care, include restrictions for physician oversight, barriers to reimbursement from some insurance companies. Having the law changed to collaborating physician rather than supervising physician would allow PAs to provide care especially in underserved areas where physicians are scarce.

9. PA and Practice owner of a Home Care based primary Care Medicine at Home has stated she would love to hire PA but hiring nurse practitioners is less burdensome. She also stated that she lost her supervising physician and was not able to practice, although NPs on her team could.

10. I recently returned to the area where I grew up to work in a FQHC in Cecil and Harford County. I have over 20 years of clinical experience. I have been trained, and have a experience in a variety of office procedures, including placing contraception into the arm, and insert and remove Intrauterine devices. My supervising physician works clinical on alternating days, and alternating sites but is always available by phone. There are many excellent clinicians onsite who have training and experience, but since advanced duties must be witnessed by a physician. I cannot get board approval to perform these procedures. This causes increased healthcare costs, and patient burden to have to schedule another appointment with another provider who they are not likely to know, or a specialist that is farther away. My patients have difficulty getting transportation to my clinic, and are hesitant to travel farther for care they could otherwise get near to their home with the clinician they trust.

11. As (an educator), I need to report how extremely difficult it is for our graduates to obtain a license to practice in Maryland. Former Governor Hogan and current Governor Moore asked (my program) specifically to train more PAs and retain them in Maryland to help bolster the state's shortage of healthcare providers. They have provided additional funding to (our) PA program to hire more faculty and provide more classrooms and labs for our students. Prior to this funding, we took 40 students per cohort; with the Governors' generosity and focus toward the healthcare of the state's citizens, we now take 60 students per cohort. The BOP refuses to recognize our students' successful passage of their board examination (the PANCE) easily looked up by anyone on the NCCPA website (the board exam and PA certification organization). (Our program) is required to provide the BOP verification of graduation signed and sealed by (our) registrar, denoting the exact dates of attendance and the degree/credential awarded, which is the MS Health Science, PA Concentration. Rather than accepting and being satisfied by our exact submissions that follow their own requirement 100%, the BOP forces our graduates to prove they graduated as a PA by submitting a copy of their diploma, making them jump through unnecessary hoops. We have also provided official transcripts to the BOP, with the exact credential noted. Our graduates are extremely frustrated at these unfair and unfathomable extra steps, costing them months of extra wait time to be awarded their license, further delaying their opportunity to earn incomes with Maryland healthcare employers they secured prior to graduation. Many of our graduates have turned away from Maryland, opting to work in PA, DE, VA and the District of Columbia, where their respective Medical Boards treat our graduates fairly. The State of Maryland/BOP asks any PA applying for licensure

to be over the age of 18 and successfully pass the PANCE, which one is not eligible unless they graduated from a fully-accredited PA program, which UMB is and has been since 1996 (UMB took over the AACC PA program in 2022). With over 93% of our graduates desiring to remain and work in Maryland, what the BOP is doing to them is unacceptable.

12. As a PA, I am often recruited for positions in both distant and neighboring states. I am also interested in these opportunities that exist for the PA students I teach as a professor of PA medicine at Frostburg State. In Maryland, PA's are currently restricted in practice, reimbursement, and placement. I continue to practice in Maryland because I'm established, I have pride in my community, and I think we have reasonable people willing to help each other out. I would like the PA students I teach to be able to apply their skills here. I want them to treat my neighbors as we age and my children when they need quality care. We need laws that allow the next generation of PA's to provide that care. Otherwise, they'll be using their skills elsewhere.

13. I had a patient with a percutaneous abdominal drain placed by IR at the hospital come to the office desperate to have the drain removed secondary to unmanageable pain at the site. She would not have been able to get an appointment to have the drain removed by IR at the hospital for several days. Typically surgeons/surgical PAs in the community would not remove a drain placed by a radiologist. We routinely send them back to the hospital as an outpatient. The day in question was a Friday and I couldn't let her go through the weekend with the painful drain that had already been deemed appropriate to remove by imaging. After consulting with my collaborating surgeon, I removed the drain for her with immediate relief of the pain. She was extremely grateful that I did not turn her away and make her wait for an appointment at the hospital. Monitoring the competency of a PA to perform an "advanced duty" is an antiquated concept created many years ago when the PA profession in Maryland was emerging clearly with the intent to create guardrails for patient safety. It is extremely arbitrary to come up with a laundry list of duties deemed "advanced" and minimum numbers performed as marker of competency for all PAs across the board. The determination of competency should be made at the practice level between the PA and the proctor/mentor. This can and routinely does happen in both regulated and unregulated practice locations with no direct evidence of patient harm. The long regulatory process of applying for, providing proof, and waiting for approval just means more patients are waiting to access the care they need especially in the outpatient setting.

14. I am currently challenged with a PA going on maternity leave, and getting coverage for her. The hurdles we have to jump through to allow other PAs help with this practice are time consuming an unnecessary.

15. I currently have two delegation agreements for the same job and I almost never work with either of those physicians.

16. I am a primary care provider in a medically underserved area I do not practice at the same site as my supervising physician, making it virtually impossible to meet requirements for more basic advanced duties to be approved.

17. I have performed life saving intubation on hundreds of patients but per state law I can no longer perform that procedure because my collaborating physician doesn’t perform that skill.

18. You don't need to be in an underserved or rural community not to have access to healthcare particularity specialty care. The professional medical community is retiring at a fast rate which will result in fewer options for patients to access healthcare. PAs are part of the solution to fulfill Maryland's healthcare workforce shortage by removing legislative barriers."

19. In my current role, working in a hospital located in an underserved community, we are often encountering patients that are suffering from neurosurgical emergencies that may have been avoided had they had better access to primary health care/preventative healthcare in their community. I would like to think that the time I spend with each patient and their families/support network, discussing the importance of preventative management and arranging for case management and social work to assist those in need of financial support, home support, makes a difference in the community. In many cases, the patients are speaking another language and providers are unable to take the time to spend working with an interpreter to educate and communicate a long-term plan with the patients. As a PA, we focus on these areas, which are critical and important for the compliance and success and improved health outcomes in patients.

20. Previously working in an outpatient neurology office, I was tasked with becoming the primary provider to treat headache and chronic migraine conditions. There are a few procedures, such as Botox, trigger point injections, nerve block injections. Very quickly, I was able to learn the procedures with training from the physicians, conference workshops and also pharmaceutical training. I was treating several patients a day who required these procedures and became more skilled at the procedures than some of the physicians. Therefore, patients were requesting my services to the office. However, due to the advanced duty requirements, the physicians continued to have to observe me performing these procedures until approval. This not only put a burden on the physicians, but also delayed their patient appointments as well as mine because of the high number of procedures I was performing per day. Ultimately, this impacted patients because the physicians would have to block part of their schedule from seeing patients during those times so they were able to observe. Neurology is already limited in access in the area and have very long waitlists for patients to be seen. In many cases, the physicians would remark on the fact that I, the PA, had more experience doing these injections and should be observing them rather than the other way around.

21. Maryland commonly sees delays in patient care in highly densely populated areas such as Baltimore. This is due to high PA restriction supervision requirements, especially if a supervising physician is not readily available.

22. Cardiology PA and in role have helped to develop a structural program in western MD increasing access to care for interventions to a large area of communities we serve in the mountain MD and the surrounding Tristate area including WV and PA of UPMC Western MD. Currently have launched LAAO procedure for our patients and community and recently got CMS approval to start TAVR procedures which will allow for patients needing aortic valve replacement and are not surgical valve replacement candidates, to undergo procedure locally and avoiding the burden of traveling to tertiary care centers hours from home (which is currently the process in place). And we are very excited to be able to offer this service which will be provided by our interventional/structural hesrty team along with our well known, cardiac surgery colleague,& team. Advanced duties addendums are cumbersome and not all inclusive to my duties on a day to day basis to assist my supervising attending, interventional/structural cardiologist. Practicing within his scope and my hospital Delineation of privileges is of the Utmost importance but current state delegation agreements and advanced duty addendum requirements, inhibit practicing to the full extent of my PA license at times and which ultimately can delay patients' care

and overall patient access to our sub specialty service line, which is already very limited in our rural, underserved community!

23. DA and advanced duty addendums have become more archaic thing of the past in other states across the country for PA practice. For a state that tends to be progressive for most all things, these current PA state practice laws requirements need to be reevaluated to align with the AAPA and other majority of other policy laws and regulations to not act merely as a constraint to practicing as a PA in Maryland and mostly importantly limiting patients access to care in areas and communities like ours that need it the most.

24. I have been able to provide access to patient care for medically underserved populations in outpatient mental/behavioral health for ages 3 and older, with more than 340 patient appointments per month. Employers have been hesitant to hire despite qualifications and the patient need specifically related to the "hassle" of applying through the administrative process and wait time for the several steps required by the Board of Physicians. This has been confusing for employers especially when PAs have their own board examinations for certification, licenses to practice medicine and prescribe, and independent liability insurance. It took me well over 6 months and 100+ hours to assist an employer through navigating with the Board of Physicians due to this confusion, tiers of application review, antiquated electronic platform/interface, and lengthy processing.

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[i] https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician