STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives
Committee on Veterans' Affairs Subcommittee on Health

Re: VA's Federal Supremacy Initiative: Putting Veterans First?

September 19, 2023

Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to submit the following statement to the U.S. House of Representatives Committee on Veterans Affairs Subcommittee on Health as part of a hearing concerning the "VA's Federal Supremacy Initiative: Putting Veterans First?" The AMA commends the Committee for focusing on this critically important issue since it is imperative that our nation's veterans receive the best health care possible.

"The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,298 health care facilities, including 171 VA Medical Centers and 1,113 outpatient sites of care of varying complexity (VHA outpatient clinics) to over 9 million Veterans enrolled in the VA health care program."[1] Since the VHA is such a large health care system, the actions it takes, especially in terms of the scope of practice of its non-physician providers, could have an immense impact on health care in its entirety. National Standards of Practice developed by the VA Federal Supremacy Project would override long-established state laws governing scope of practice and health-professional licensure, and, as such, the quality of care provided to our veterans, and potentially patients across the nation, will decline if the Project is fully implemented. We therefore oppose the implementation of the Federal Supremacy Project. At the very least, we urge Congress to ensure that physician-led team-based care is maintained and that physician representation on all the Work Groups, not just the Physician Work Group, be mandatory.

The VA Federal Supremacy Project: Physician representation is necessary across all stages and Work Groups.

In November 2020, the VA published an interim final rule entitled "Authority of VA Professionals to Practice Health Care."[2] The interim final rule was issued to expand health care professionals' scope of practice "notwithstanding any State license, registration, certification, or other requirements... This rulemaking also confirm[ed] VA's authority to establish national standards of practice for health care professionals which will standardize a health care professional's practice in all VA medical facilities."[3] By invoking the Supremacy Clause of the Constitution to preempt state laws to develop National Standards of Practice, the VA is making it harder to oversee the practice of medicine and is potentially allowing non-physicians to perform procedures that are outside the scope of their knowledge and state licensure.

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[1] https://www.va.gov/health/aboutvha.asp#:~:text=The%20Veterans%20Health%20Administration%20(VHA,Veterans%20enrolled%20in%20the%20VA.

[2] https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care#p-65.

[3] *Id*.

Based upon this interim final rule, the VA has begun the process of implementing National Standards of Practice for 48 health care occupations through the "Federal Supremacy Project." As noted in the rule, this Project preempts state scope of practice laws and creates a single set of practice standards for all VA-employed physicians, and separate standards for 47 other non-physician health care professionals. The VA has already closed the comment period for Blind Rehabilitation Specialists, Ophthalmology Technicians, Kinesiotherapists, Therapeutic Medical Physicists, Registered Dietitian Nutritionists, Orthotists, Prosthetists, and Prosthetist-Orthotists, Histopathology Technologists, and Cytotechnologists.[4] Moreover, comment periods are currently open for Art Therapists, Dance/Movement Therapists, Drama Therapists, Music Therapists, and Recreation Therapists and close on September 26, 2023. Finally, the VA is currently hosting five listening sessions to allow individuals to provide input on state variances for health care occupations for the occupations that have not yet had their feedback period closed, including Optometrists, Nurse Practitioners, Physician Assistants, and Pharmacists.[5]

Physician-led, team-based care is the gold standard of health care and the predominant model of care for many, if not most, of these occupations across the country. As such, due to the physician's unique role as head of the care team, it is important that physician input is received and implemented within the Project as early as possible. Importantly, physician representation on all the Work Groups, not just the Physician Work Group, should be mandatory since it could help to counter internal and external resistance when National Standards of Practice are published in the Federal Register for comment and help to ensure that these standards are accurate and built to help enforce team-based care. Therefore, if the VA persists in moving forward with the Federal Supremacy Project, we urge the VA to require physician representation on all Work Groups and consultation with relevant physician specialty societies and other internal and external stakeholders.

Scope of Practice: Physicians should be the head of the care team to ensure the highest quality care for our nation's veterans.

Should the VA move forward with the Federal Supremacy Project, the AMA is concerned that the National Standards of Practice for non-physician providers developed by the Project may not accurately reflect the skills acquired through the education and training of such occupations and may allow non-physicians to provide services and perform procedures that are outside the scope of their knowledge and licensure. The AMA strongly supports the team approach to patient care, with each member of the team playing a clearly defined role as determined by his or her education and training. While we greatly value the contribution of all non-physicians, no other health care professionals come close to the education and training that physicians receive.

With more than 12,000 hours of clinical experience, physicians are uniquely qualified to lead health care teams. Non-physicians such as physician assistants, nurse anesthetists, pharmacists, and optometrists do not have the same rigorous and comprehensive education as physicians. For example, physician assistant programs are two years in length, require 2,000 hours of clinical care, and have no residency requirement.[6] Similarly, nurse anesthetists complete only two-to-three years of graduate level education and have no residency requirement. Pharmacists are trained as experts in medication management but have very limited direct patient care experience and are not trained to independently diagnose and treat patients. Students of optometry rarely complete postgraduate

[4] https://www.va.gov/STANDARDSOFPRACTICE/providing-feedback.asp.
[5] https://www.federalregister.gov/documents/2023/08/14/2023-17309/announcement-of-public-listening-sessions-to-inform-vas-standards-of-practice.
[6] https://www.ama-assn.org/system/files?file=corp/media-browser/premium/arc/ama-issue-brief-independentnursingpractice.pdf.

education and are trained in primary eye care. They are not exposed to standard surgical procedure, aseptic surgical technique, or medical response to adverse surgical events. In short, the educational programs undergone by non-physicians do not prepare them to develop clinical judgment or skills similar to a physician. For this reason, physicians and non-physicians are not interchangeable on a care team.

But it is more than just the vast difference in hours of education and training, it is also the difference in rigor, standardization, and comprehensiveness of medical school and residency programs, compared to other non-physician programs. To be recognized as a physician with an unlimited medical license, medical students' education must prepare them to enter any field of graduate medical education. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, physiological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. This level of education and training is necessary to develop the acumen required for the independent practice of medicine, including diagnosing and treating patients, performing eye surgery and administering anesthesia.

There is deep concern that the VA removing scope of practice safeguards will allow for non-physician practitioners who have not been adequately trained to provide medical care or perform procedures that are outside the scope of their expertise and licensure, ultimately leading to a lower standard of care for veterans. Veterans are an extremely complex patient population. Consequently, our veterans deserve better—they deserve and have a right to have physicians leading their health care team.

Increased Cost and Decreased Quality: Increasing non-physician practitioners' scope of practice within the VHA increases cost and decreases the quality of health care.

There is strong evidence that increasing the scope of practice of non-physicians in the VA results in higher costs and worse outcomes for veterans' health care. For example, a high-quality study published as a working paper by the *National Bureau of Economic Research* in 2022 compared the productivity of nurse practitioners and physicians (MDs/DOs) practicing in the emergency department using Veterans Health Administration data. The study found that nurse practitioners use more resources and achieve worse health outcomes than physicians. Nurse practitioners ordered more tests and formal consults than physicians and were more likely than physicians to seek information from external sources such as X-rays and CT scans.[7] They also saw worse health outcomes, raising 30-day preventable hospitalizations by 20 percent, and increasing length of stay in the emergency department. Altogether, nurse practitioners practicing independently increased health care costs by $66 per emergency department visit.[8] The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for

[7] *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.
[8] *Id.*

differences in salary.[9] The authors estimate that continuing to use the current staffing allocation of nurse practitioners in the emergency department results in a **net *cost* of $74 million per year**, compared to staffing the emergency department with only physicians. Not only does the increased resource use by nurse practitioners result in increased costs and longer lengths of stay, but it also means patients undergo unnecessary tests, procedures, and hospital admissions.

This study is a uniquely high-quality study within this body of literature because it measures nurse practitioners working within the VHA system during a time when nurse practitioners were authorized to practice without physician supervision. It also uses a high-quality causal analysis. While the VA national standards of practice do not include nurse practitioners, this study is informative as the VA considers expanding the scope of practice of other non-physician practitioners, including physician assistants. In short, education and training matters. The authors note that these findings may reflect poorer decision making by nurse practitioners based on their lower level of skill compared to physicians—causing them to seek additional sources of information. While it is appropriate for nurse practitioners to seek additional information when they are unsure or unable to make a differential diagnosis and determine the appropriate course of treatment, this path results in increased costs to the system and worse patient outcomes, ultimately a lower quality of care for veterans.

These findings are consistent with other studies as well, including a recent study from the Hattiesburg Clinic in Mississippi which found that allowing physician assistants and nurse practitioners to function with independent patient panels in the primary care setting resulted in higher costs, higher utilization of services, and lower quality of care compared to panels of patients with a primary care physician. Specifically, the study found that non-nursing home Medicare ACO patient spend was $43 higher per member, per month for patients on a nurse practitioner/physician assistant panel compared to those with a primary care physician. Similarly, patients with a nurse practitioner/physician assistant as their primary care provider were 1.8 percent more likely to visit the ER and had an eight percent higher referral rate to specialists despite being younger and healthier than the cohort of patients in the primary care physician panel. On quality of care, the researchers examined 10 quality measures and found that physicians performed better on nine of the 10 measures compared to the non-physicians.

Other studies further suggest that physician assistants and nurse practitioners tend to overprescribe and overutilize diagnostic imaging and other services, contributing to higher health care costs. For example, a 2020 study published in the *Journal of General Internal Medicine* found 3.8 percent of physicians (MDs/DOs), compared to 8 percent of nurse practitioners and 9.8 percent of physician assistants met at least one definition of overprescribing opioids and 1.3 percent of physicians compared to 8.4 percent of physician assistants and 6.3 percent of nurse practitioners prescribed an opioid to at least 50 percent of patients.[10] The study further found that, in states that allow independent prescribing, nurse practitioners and physician assistants were 20 times more likely to overprescribe opioids than those in prescription-restricted states.[11]

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[9] *Id*.

[10] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584-2592.

[11] *Id*.

Multiple studies have also found that physician assistants and nurse practitioners tend to prescribe unnecessary antibiotics.[12] A study in *Infection Control & Hospital Epidemiology* which examined prescribing data for patients with common upper respiratory infection that should not require antibiotics and found that adults seen by nurse practitioners or physician assistants were 15 percent more likely to receive an antibiotic compared to those patients seen by a physician. Similar rates were found for pediatric patients.[13] Unnecessary antibiotic prescribing leads to antibiotic resistance which can have negative impact on a patient's future ability to fight infection.

Multiple studies have also shown that physician assistants and nurse practitioners order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal X-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—more than 400 percent—by non-physicians, primarily nurse practitioners and physician assistants, during this time frame.[14] A separate study published in *JAMA Internal Medicin*e found that physician assistants and nurse practitioners ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[15] The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding physician assistant or nurse practitioner scope of practice.

The findings are clear: nurse practitioners and physician assistants tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and overprescribe antibiotics[16]—all which increase health care costs and threaten patient safety.

Finally, it is important to ensure that certified registered nurse anesthetists are properly overseen. There is no literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight. For example, a study from *Anesthesiology*, found that patients having general or orthopedic surgery were eight percent more likely to die if anesthesia was not provided by a physician anesthesiologist.[17] An additional study from the *Journal of Clinical Anesthesia* found that patients that had their anesthesia solely provided by a nurse anesthetist rather than a physician

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[12] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infectious Diseases*. 2016:1-4. Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. *JAMA* 2009; 302:758–66.

[13] Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. *Infection Control & Hospital Epidemiology*. 2018:1-9.

[14] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.

[15] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.

[16] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

[17] Silber JH, Kennedy SK, Even-Shoshan O, et al. Anesthesiologist direction and patient outcomes. *Anesthesiology*. 2000;93(1):152-163. doi:10.1097/00000542-200007000-00026.

anesthesiologist were 80 percent more likely to have an unexpected disposition (admission to the hospital or death).[18] Furthermore, a study from *VA Evidence Synthesis Program Evidence Briefs*, found that after the VA reviewed its own research resources, the VA's Quality Enhancement Research Initiative concluded that there was no evidence to support the safe implementation of nurse-only models of anesthesia for the VA especially for complex surgeries and in small or isolated VA hospitals.[19] Lastly, multiple studies have found that when states choose to remove the Medicare physician supervision requirement for nurse anesthetists there is no evidence that access to care increases.[20]

Nurse practitioners, nurse anesthetists, and physician assistants are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. We urge Congress to invest in the proven track record of physician-led team-based care.

Patients Want Physicians: Patients have consistently stated that they want a physician as the head of their care team.

In developing National Standards of Practice, patient sentiment should be considered and support for physician-led teams should be enhanced. Based on a series of nationwide surveys, patients overwhelmingly want physicians to lead their health care team. Four out of five patients want a physician leading their health care team and 95 percent believe it is important for physicians to be involved in their medical diagnoses and treatment decisions (68 percent said it is very important). Moreover, only three percent of U.S. voters said it was not important to have physicians involved in specific treatments such as anesthesia, surgery, and other invasive procedures.[21] Patients understand the value that physicians bring to the health care team and expect to have access to a physician to ensure that their care is of the highest quality. As such, developing National Standards of Practice that will potentially remove physicians from many veterans' health care teams goes against what patients want, which will decrease the quality of care received, patient confidence, and the effectiveness of the VHA.

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[18] Memtsoudis SG, Ma Y, Swamidoss CP, Edwards AM, Mazumdar M, Liguori GA. Factors influencing unexpected disposition after orthopedic ambulatory surgery. *J Clin Anesth*. 2012;24(2):89-95. doi:10.1016/j.jclinane.2011.10.002.

[19] McCleery E, Christensen V, Peterson K, Humphrey L, Helfand M. Evidence Brief: The quality of care provided by advanced practice nurses. In: *VA Evidence Synthesis Program Evidence Briefs*. Washington (DC): Department of Veterans Affairs (US); September 2014.

[20] Schneider JE, Ohsfeldt R, Li P, Miller TR, Scheibling C. Assessing the impact of state "opt-out" policy on access to and costs of surgeries and other procedures requiring anesthesia services. *Health Econ Rev.* 2017;7(1):10. doi:10.1186/s13561-017-0146-6; *see also,* Sun EC, Dexter F, Miller TR, Baker LC. "Opt out" and access to anesthesia care for elective and urgent surgeries among U.S. Medicare beneficiaries. *Anesthesiology*. 2017;126(3):461-471. doi:10.1097/ALN.0000000000001504; Sun E, Dexter F, Miller TR. The effect of "opt-out" regulation on access to surgical care for urgent cases in the United States: evidence from the National Inpatient Sample. *Anesth Analg.* 2016;122(6):1983-1991. doi:10.1213/ANE.0000000000001154.

[21] https://www.ama-assn.org/system/files/ama-scope-of-practice-stand-alone-polling-toplines.pdf. The survey was conducted among 1,000 U.S. voters between January 27th and February 1st, 2021. The margin of error is +/- 3.5 at the 95% confidence interval.

State Based Licensure: The Federal Supremacy Project undermines state licensing boards and will further encourage inadequate oversight of non-physician practitioners within the VA.

State licensing boards play an important role in ensuring that medical care is properly administered and that providers are disciplined when malpractice is committed. Such laws are often the result of extensive debate by state legislatures, sometimes spanning several years and involving negotiations among all stakeholders. However, the VA's decision to circumvent state scope of practice laws and regulations through the Federal Supremacy Project will make it impossible for state boards to oversee physicians and non-physician practitioners employed by the VA, leading to unintended consequences.[22]

Unlike physicians who are supposed to have their licenses reviewed every two years by the VA, registered nurses and other non-physician practitioners within the VA are appointed for an indefinite time, meaning that their credentials are reviewed before they are hired and may never be reviewed again.[23] As a result, according to multiple Government Accountability Office (GAO) audits, the VA is doing an inadequate job of supervising and disciplining its non-physician practitioners. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA providers.[24] The issues reported range from providers lacking appropriate qualifications, to poor performance and provider misconduct.[25] Unfortunately, the VA has been deficient in putting an end to this subpar care in part, due to the fact that VA medical center officials lack the information they need to make decisions about providers' privileges due to poor VA reporting. Owing to the VA's inadequate oversight, VA medical center officials are not reviewing all of the providers for whom clinical care concerns were raised, and the VA is not taking appropriate adverse privileging actions.[26] This includes certain VA medical centers not reporting providers to the National Practitioner Data Bank (NPDB) or to state licensing boards as is required by law.[27] If the National Standards of Practice are implemented the oversight that these non-physician practitioners have will be lowered even more, leading to an increased lack of accountability for Veteran's care. Moreover, it will make it extremely difficult for state boards to oversee the practitioners that they license and will make it all but impossible to discipline VA-employed non-physician practitioners who inadequately care for Veterans. This lack of oversight means that patients' safety could easily be jeopardized, especially if the national standard for a particular provider-type differs from a state's scope of practice and licensing requirements. In these cases, it would be unclear whether the VA provider would have the necessary training, as dictated by the state licensing or medical board, to appropriately treat a patient and could potentially lead to Veterans receiving subpar care with little to no repercussions for the provider.

Since the VA already has numerous problems with quality of care, the VA should not expand its scope of practice parameters and allow non-physician practitioners to perform procedures for which they are not properly licensed or trained. By implementing the Federal Supremacy Project, the VA is making it difficult for state boards to oversee the practitioners that they license and will likely make it tougher to discipline non-physician practitioners who inadequately care for patients due to a lack

[22] The vast majority of states support physician-led teams. For example, 38 states plus DC require physician supervision of physician assistants (PAs) and 11 states require PAs to practice pursuant to a collaboration agreement with a physician. Similarly, 20 states require physician involvement for nurse practitioners to diagnose, treat or prescribe and 14 more states require physician involvement for a certain number of hours or years of practice.
[23] https://www.gao.gov/assets/700/697173.pdf.
[24] https://www.gao.gov/assets/710/702090.pdf.
[25] *Id*.
[26] *Id*.
[27] *Id*.

of clarity about these practitioners' scope of practice. Since it has been shown that the VA is unable to adequately oversee health care providers, it is vital to rescind or restructure the Federal Supremacy Project and ensure that state licensing boards can adequately supervise their non-physician practitioners to ensure the highest quality of care for veterans.[28]

We also believe that the IFR did not meet the standards set out in Executive Order 13132 and, by extension, is in violation of the Administrative Procedure Act (APA). The IFR preempts state law by asserting that state and local scope of practice laws relating to NPPs that are employed by the VA "will have no force or effect," and that state and local governments "have no legal authority to enforce them." However, the requirements to preempt state law, set forth in Executive Order 13132, have not been met.[29] The VA did not "provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings."[30] This can be seen by the fact that the VA did not provide any time for comments and instead published the IFR on the same day the rule took effect, which gave no opportunity for any stakeholders to meaningfully participate in the proceedings.[31] As such, the VA did not follow the guidelines set out in Executive Order 13132 and "act only with the greatest caution," nor did the VA possess good cause when it bypassed the APA and acted arbitrarily and capriciously by failing to adequately consider the rights of the states and the long-term safety of our nations' Veterans.

Electronic Health Record (EHR): The VA should not be granted uniform practitioner privileging as a result of their inadequate EHR system.

In the Interim Final Rule, the VA argued that non-physician practitioners need to practice independently due to the newly created EHR which purportedly requires uniform privileging irrespective of where care is delivered.[32] "An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users."[33] EHRs also provide privileging options, meaning that they will provide only a certain amount of access and authority to providers depending on their licensure. Despite multiple EHR systems across the U.S. allowing for differing levels of privileging, the VA argued that it must develop uniform standards of practice because the new EHR system, which it developed in conjunction with the Department of Defense over the course of years, requires all practitioners with the same license to have the same practice privileges. However, the VA recently announced that it will indefinitely delay the implementation of its EHR system due to multiple problems, including increased cost, and significant issues which have led to the death of multiple veterans.[34,35] With this rationale removed from consideration, the VA should not be rewarded with a universalized privileging system for building a $10 billion EHR system that is subpar, defunct, and does not meet state scope of practice laws.[36] Moreover, if there must be uniform privileging in the VA, then instead of setting practice privileges to align with the least restrictive

[28] https://www.gao.gov/assets/700/697173.pdf.
[29] https://www.govinfo.gov/content/pkg/FR-1999-08-10/pdf/99-20729.pdf.
[30] *Id.*
[31] *Id.*
[32] https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care#p-65.
[33] https://www.healthit.gov/faq/what-electronic-health-record-ehr.
[34] https://digital.va.gov/ehr-modernization/resources/ehr-deployment-schedule/; https://subscriber.politicopro.com/article/2023/04/vas-new-health-records-system-contributed-to-4-deaths-00090830?source=email.
[35] https://digital.va.gov/ehr-modernization/resources/ehr-deployment-schedule/.
[36] https://www.gao.gov/assets/710/700478.pdf.

scope provisions, the VA should ensure that veterans are provided with the best care and adhere to the most conservative state scope requirements.

Alternate Solutions to VA Health Care Needs

The AMA understands the importance and need to have an adequately staffed health care facility. As such, we suggest that, instead of implementing the Federal Supremacy Project, additional funding is provided to the VHA to hire and train more physicians. Simultaneously, the VHA needs to accurately count all physicians providing care within its facilities, including trainees, to accurately understand where shortages exist and appropriately adjust hiring accordingly. The GAO has consistently found that the VHA is unable to accurately count the total number of physicians who provide care in its VA medical centers (VAMC) and the VA has disagreed with the recommendation of the GAO to develop and implement a process to accurately count all physicians providing care at each medical center.[37,38]

The VA is the largest provider of health care training in the United States. "In general, each year approximately 43,000 individual physician residents receive their clinical training by rotating through about 11,000 VA-funded physician FTE residency positions at VA medical facilities."[39] However, approximately 99 percent of the VA's programs are sponsored by outside medical schools or teaching hospitals. Functionally, this limits the amount of expansion that can occur in the VA system as those who train at VA locations must still be housed under a third-party graduate medical education (GME) program with full accreditation and administrative functioning. Therefore, the VA should work to create more of its own GME residency positions as well as continue to work with medical schools to expand existing partnerships and shared training slots. A few of the ways this could be accomplished include expanding the VA Pilot Program on Graduate Medical Education and Residency[40] and expanding the number of positions available via the VA MISSION Act of 2018[41] and the Veterans Access, Choice and Accountability Act.[42] Expansions could be made through the Department of Veterans Affairs Office of Academic Affiliations to help preserve and expand GME within the VHA. The expansion of GME within the VHA has already proven to be successful in retaining physicians. For example, the annual Trainee Satisfaction Survey administered by the VA Office of Academic Affiliations to physician residents consistently finds that residents have a more positive opinion regarding a career at the VA after completing their rotations, with over half (55 percent) responding they would consider a career at a VA medical center.[43] If the full funding for the direct and indirect costs of GME positions was expanded within the VA more physicians would be able to work within the VA, which would decrease existing shortages while providing high quality care for veterans.

For the first time in years the staffing shortages within the VHA have intensified, resulting in a 22 percent increase in occupational staffing shortages in 2022 compared to 2021. [44] Some of the professions with the severest shortages within the VHA include psychiatrists, primary care

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[37] https://www.gao.gov/products/gao-18-124#summary_recommend.
[38] https://www.gao.gov/assets/gao-22-105630.pdf.
[39] https://sgp.fas.org/crs/misc/R44376.pdf.
[40] https://www.federalregister.gov/documents/2022/02/04/2022-02292/va-pilot-program-on-graduate-medical-education-and-residency.
[41] https://www.govinfo.gov/content/pkg/COMPS-15905/pdf/COMPS-15905.pdf.
[42] https://www.govinfo.gov/content/pkg/COMPS-15905/pdf/COMPS-15905.pdf.
[43] https://journals.lww.com/academicmedicine/Fulltext/2022/08000/Veterans_Affairs_Graduate_Medical_Education.37.aspx.
[44] https://www.va.gov/oig/pubs/VAOIG-22-00722-187.pdf.

physicians, and gastroenterologists.[45] As such, another potential solution to the physician shortage is to hire more physicians and provide additional benefits to physicians working within the VA to help with retention.

Within the VHA, physician salaries are determined according to a combination of base pay, market pay, and performance pay. Moreover, under 38 U.S.C. 7431(e)(1)(A),[46] every two years the Secretary must prescribe for Department-wide applicability the minimum and maximum amounts of VHA physicians annual pay.[47] Therefore, under this statue, it would be possible to increase the pay offered to physicians within the VHA which would help with recruitment and retention. Furthermore, the VA should enhance its loan forgiveness and scholarship efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.

Additionally, ensuring that all physician specialties are direct hires and streamlining the hiring process in general will help with the efficient and timely staffing of physicians. The hiring process for international medical graduates (IMG) should also be streamlined, including providing/expanding the exception to the two-year home country return requirement if an IMG works for the VHA for a designated period of time. The VA states for all its jobs that the hiring process "may take a while." In line with this, 94 percent of respondents to a survey about VA hiring stated that they had lost an interested candidate due to delays in the HR hiring process.[48] As such, changes need to be made to the hiring and onboarding process so that good candidates are not lost to other jobs.

Finally, increasing access to the Community Care program when physician employment gaps cannot be filled will help to ensure that veterans continue to receive the care they need and increase access to physician services. However, the implementation of this program must be improved, including resolving delays in payment to participating providers. For example, a 225-bed health care system in South Carolina had $22.7 million in outstanding VA claims at the beginning of FY 2022 with $16.7M (83 percent) over 90 days due. On top of this, the health care system had to write off approximately $12.7M during FY 22 because the VA claims were over 300 days old. As such, increasing reliability of payment for services rendered as part of the Community Care program and increasing the number of physicians and other health care professionals who are part of the program could help to fill workforce gaps.

In line with this, the VHA should pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician and ensure that clean claims submitted electronically to the VA are paid within 14 days and that clean paper claims are paid within 30 days. This would increase the willingness and variety of providers who would care for our veterans.

Conclusion

Our nation's veterans should be provided with physician-led health care teams that consider important scope of practice limitations and make the most of the respective education and training of physicians and non-physician practitioners. Therefore, we oppose the implementation of the VA

[45] https://www.va.gov/oig/pubs/VAOIG-22-00722-187.pdf.
[46] https://www.govinfo.gov/content/pkg/USCODE-2018-title38/html/USCODE-2018-title38-partV-chap74-subchapIII-sec7431.htm.
[47] https://www.federalregister.gov/documents/2019/12/09/2019-26435/annual-pay-ranges-for-physicians-dentists-and-podiatrists-of-the-veterans-health-administration-vha.
[48] https://www.afge.org/globalassets/documents/generalreports/2023/03/vhpireport_v2.pdf.

Federal Supremacy Project. Instead, additional investments in physicians and physician-led team-based care should be made to ensure that veterans receive the care they deserve. At the very least, we urge Congress to ensure that physician-led team-based care is maintained and that physician representation on all the Work Groups, not just the Physician Work Group, be mandatory.