

Increasing Access to Medical Care from Physicians through an Associate Physician License Option

Jeremy J. Snavely

By 2033 the United States will see a physician shortage of up to 139,000 physicians.¹ This is not just a disaster waiting to happen; in most states the disaster has already arrived. Take Arizona for example. Arizona's primary care physician shortage is one of the worst in the nation, with the state ranking 44th out of 50 states, according to information from the University of Arizona College of Medicine.²

Nationwide, physician shortages are exacerbated by a growing deficit of post-graduate residency program training positions for medical school graduates. Every year, about 8,000 medical school graduates who apply to U.S. residency programs currently fail to match with a program.³ Their progress to entering practice to serve patients is thus set back, or in some cases permanently ended. Also, the average graduate (in 2017) has more than \$180,000 in debt, which naturally will be much more difficult to pay off without being able to practice.⁴

Resolving these problems means tackling a number of flawed federal policies. For example, residency programs depend on Medicare funding, with a funding cap that was pegged to 1997 levels until December 2020 when Congress increased this funding for the first time. Meanwhile, there are important state-based solutions that can be implemented. SB 1271, a bill introduced in Arizona during the 2021 legislative session, following the example of innovative states like Missouri, sets in motion one such solution.

Under current statute, as in nearly every state, eligibility to apply for an Arizona medical license requires successful completion of a 12-month post-graduate hospital internship, residency, or clinical fellowship program approved by the Accreditation Council for Graduate Medical Education (ACGME). However, by the time medical school students graduate, they may have more than twice as much clinical experience as nurse practitioner graduates who are eligible to apply for a license to practice in Arizona. Medical school graduates have completed at a minimum 65 weeks of supervised clinical training by the time they graduate, compared to a minimum of 27.5 weeks for nurse practitioners (NPs).⁵

A growing number of states have begun to roll back the harmful monopoly the ACGME holds on the ability of medical graduates to obtain any type of license, supervised or otherwise. Missouri's Assistant Physician Law, proposed by Dr. Keith Frederick, took effect more than six years ago on Aug 28, 2014, and is enacted as Missouri Statute 334.036 & 334.037. The legislation's effect in Missouri has been to enhance patient care.⁶ Georgia, New Hampshire, and Virginia are among other states that have introduced, but not yet adopted, related legislation.

In 2015 Arkansas passed the Arkansas Graduate Registered Physician Act. Utah passed H.B. 396, Medical School Graduates Associate Physician Licensure, in 2017. However, the Heritage Foundation reports, "Although these reforms are definitely a step in the right direction, these states have also imposed a number of unnecessary restrictions on their provisional

licenses that seem to be counterproductive."⁷

On the other hand, critics say the reforms go too far.⁸ A number of misplaced concerns are being put forward about these measures, specifically regarding the Arizona proposal, SB 1271, which as of this writing has been approved by the Arizona Senate Committee on Health and Human Services and is making its way through the legislative process.

Claim: SB 1271 proposes creation of a new class of physician.

Fact: The bill does not propose a new class of physician. It would simply begin a process of expanding training options for medical school graduates. The associate physician (AP) license would in essence be a variation of the existing "post-graduate training permit" already issued by the State of Arizona with a few innovative differences. Graduates with this license will often use it as a bridge toward participation in traditional residency training. They can gain valuable "boots on the ground experience" under the wing of Arizona community physicians serving under-served patients while waiting for an opening. This limited license will also be a platform to safely explore new strategies for completing post-graduate training.

Claim: Access to care from associate physicians would jeopardize patient safety.

Fact: Access to an associate physician may improve patient safety, as medical school graduates have more training than many practitioners currently treating patients in rural Arizona settings. For example, 41 percent of rural Medicare beneficiaries saw a physician assistant (PA) or NP for all (17 percent) or some (24 percent) of their primary care in 2012.⁹ That percentage is no doubt higher today, as the number of NPs has increased from 91,000 in 2010 to 190,000 in 2017.

"At the point of certification, a new nurse practitioner has acquired between 500 and 1,500 hours of clinical training, fewer than a third-year medical student," reports the Primary Care Coalition. Medical school graduates, by comparison, on average complete 6,000 hours of such training by the end of their fourth year.¹⁰

Claim: Allowing associate physicians to practice in under-served areas could put the safety of some of Arizona's most vulnerable patients at risk.

Fact: "Americans who qualify for Medicare because of a disability, and dual-eligibles are all currently more likely to receive primary care from NPs than from physicians," according to an American Enterprise Institute study. As mentioned, associate physicians will have had more training than an NP graduate. In addition, the proposal mandates a collaboration agreement with a licensed physician to facilitate supervision requirements. NPs, on the other hand, are allowed unsupervised practice in the State of Arizona.¹¹

Claim: This legislation will not effectively address the shortage of residency positions, and it will not make an impact on the physician shortage.

Fact: The legislation isn't intended as a "quick fix." It is simply adding another tool in the toolbox available to medical school graduates as they continue their path toward full licensure, and gives patients increased options as well. Resolving both of these problems will require many changes. SB 1271 is just one step in a process that will also require changes at the federal level. The longest journey begins with a first step.

Claim: Most medical graduates match, so there is a small pool of potential APs, and it is a misconception that there is a shortage of residency positions, especially for primary care residency.

Fact: There are 8,000 to 10,000 unmatched medical graduates per year. Meanwhile very few residency positions go unfilled. In Arizona in 2019, all the available residency program positions were filled, except for six internal medicine and 19 general surgery positions. All the family medicine residency slots available in Arizona were filled.¹²

Claim: The proposal would allow APs to prescribe controlled substances.

Fact: As introduced, the bill would allow prescribing of only the specific controlled substances authorized by a collaboration agreement. Other supervision requirements related to prescribing controlled substances are also more stringent. Not permitting the prescribing of controlled substances, where appropriate, would be detrimental to patient care. In addition, NPs can prescribe medication, including controlled substances, in all 50 states and Washington, D.C.

Claim: It is unclear whether insurers will allow APs and their collaborating physicians to receive payment for services provided to patients, which calls into question the viability of the entire model.

Fact: Although more work on this problem is needed, practices in Missouri report that payers are beginning to cover services provided by APs. Also, APs are serving and training in innovative direct-pay practices, not dependent on insurance, that are growing in number across the country and state. In addition, Sec 32-3106 of Arizona Revised Statutes states that the legislature "shall not consider the ability or inability to obtain health insurance coverage for the proposed increased scope of practice."

Claim: A recent study in the *Journal of the American Medical Association*¹³ found that APs in Missouri had significantly lower U. S. Medical Licensing Examination (USMLE) scores compared to their colleagues who matched into a residency.

Fact: The *JAMA* article did not conclude that the APs had "significantly lower" scores. In fact, the authors did not even look at specific differences in scores; they compared first time pass rates for the exam between APs licensed in Missouri and other medical school graduates. A comparison of the passing scores of APs vs. other test takers was not within the scope of the article. Also, the article's references that claim correlation of test scores to the quality of care delivered by a physician are very limited in scope and not generally applicable to

the environment in which APs will be practicing. There is no evidence that the care being provided by APs in Missouri is unsafe. On the other hand, there is evidence of the tangible value they are adding to practices with which they collaborate.

The bottom line is that patients too often lack access to care from physicians while the training of tens of thousands of medical school graduates is wasted. While states are rushing to increase the scope of practice of non-medical school graduates, it makes no sense to keep in place anticompetitive rules that impose unfair monopolistic restrictions on the ability of medical school graduates to continue a path towards full licensure.

Jeremy J. Snavelly serves as business manager and director of regulatory affairs for AAPS. Contact: jeremy@aapsonline.org.

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