

June 1, 2023

The Honorable Jason Smith  
Chair  
Committee on Ways and Means  
1011 Longworth House Office Building  
United States House of Representatives  
Washington, DC 20515

The Honorable Cathy McMorris Rodgers  
Chair  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
United States House of Representatives  
Washington, DC 20515

The Honorable Richie Neal  
Ranking Member  
Committee on Ways and Means  
1129 Longworth House Office Building  
United States House of Representatives  
Washington, DC 20515

The Honorable Frank Pallone  
Ranking Member  
Committee on Energy and Commerce  
2322 Rayburn House Office Building  
United States House of Representatives  
Washington, DC 20515

Dear Chairpersons Smith and McMorris Rodgers and Ranking Members Neal and Pallone:

The undersigned medical professional organizations write to you in strong opposition to H.R. 2713, the “Improving Care and Access to Nurses Act,” or the “I CAN Act.” This legislation would endanger the quality of care that Medicare and Medicaid patients receive by expanding the scope of practice for nonphysician practitioners, including nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and physician assistants.

In general, we are deeply concerned that this broad, sweeping bill endangers the care of Medicare and Medicaid patients by expanding the types of services nonphysician practitioners can perform and removing physician involvement in patient care. This legislation would allow nonphysician practitioners to perform tasks and services outside their education and training and could result in increased utilization of services, increased costs, and lower quality of care for patients. Additionally, this bill will remove supervision requirements for certified registered nurse anesthetists, a change that could have a negative impact on quality outcomes for patients.

Furthermore, the lack of clarity surrounding the impact and intent of section 401, Revising the Local Coverage Determination Process Under the Medicare Program, is troubling and could lead to unintended consequences. For example, this section could be interpreted as mandating that the Secretary of the Department of Health and Human Services prevent Medicare Administrative Contractors (MACs) from imposing any limitation on the types of nonphysician practitioners who can provide specific items or services associated with a local coverage determination (LCD). This section also could be interpreted as preventing MACs from placing restrictions on nonphysician practitioners who practice at the top of their license under an LCD, irrespective of state scope of practice laws. Regardless of the proper interpretation, the assessment of civil monetary penalties up to \$10,000 for each violation of section 401 would undermine efforts by HHS and MACs, working in concert with medical experts, to develop LCDs that provide the highest quality of care for patients.

Our organizations remain steadfast in our commitment to patients who have said repeatedly that they want and expect physicians to lead their health care team and participate in their health care determinations. In a recent survey of U.S. voters, 95 percent said it is important for a physician to be

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 2

involved in their diagnosis and treatment decisions.<sup>1</sup> Patients expect the most qualified person—physician experts with unmatched training, education, and experience—to be diagnosing and treating injured or sick individuals and making often complex clinical determinations. Unfortunately, the I CAN Act runs counter to this preference by effectively removing physicians from important medical treatment decisions regarding a patient’s care.

Furthermore, despite claims to the contrary, expanding the scope of practice for nonphysician practitioners does not increase patient access in rural or underserved areas. In reviewing the actual practice locations of primary care physicians compared to nonphysician practitioners, it is clear that physicians and nonphysicians tend to practice in the same areas of the state.<sup>2</sup> This is true even in those states where, for example, nurse practitioners can practice without physician involvement. These findings are confirmed by multiple studies, including state workforce studies.<sup>3</sup> The data is clear—scope expansions have not led to increased access to care in rural and underserved areas.

While all health care professionals play a critical role in providing care to patients and nonphysician practitioners are important members of the care team, their skill sets are not interchangeable with those of fully educated and trained physicians. This is fundamentally evident based on the difference in education and training between the distinct professions.

- Physicians complete four years of medical school plus three to seven years of residency, including 10,000-16,000 hours of clinical training.<sup>4</sup>
- Nurse practitioners, however, complete only two to three years of graduate level education, have no residency requirement, and complete only 500-720 hours of clinical training.<sup>5</sup>
- Physician assistants complete two to two and half years of graduate level education with only 2,000 hours of clinical care and no residency requirement.
- Certified registered nurse anesthetists complete two to three years of graduate level education, have no residency requirement, and complete only 2,500 hours of clinical training.
- Certified nurse midwives must have an RN license and have completed a master’s program, which typically lasts two to three years. There is no residency requirement and no specific hours of clinical experience required for graduation, rather the accrediting body provides suggested guidelines for programs.
- Clinical nurse specialists complete a master’s degree but there is no residency requirement and only 500 clinical hours of training are required.<sup>6</sup>

But it is more than the difference in hours and years of training—the depth and breadth of physicians’ education is far beyond that of nonphysician practitioners. Equipped to handle any clinical scenario as the

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<sup>1</sup> <https://www.ama-assn.org/system/files/scope-of-practice-protect-access-physician-led-care.pdf>.

<sup>2</sup> <https://www.ama-assn.org/system/files/scope-of-practice-access-to-care-for-patients.pdf>.

<sup>3</sup> The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. <https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf>; Oregon Center for Nursing (2020). Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, But Not Enough to Go Around. Portland, OR, Oregon Center for Nursing, pg. 16.

<sup>4</sup> <https://www.ama-assn.org/system/files/scope-of-practice-physician-training.pdf>.

<sup>5</sup> *Id.*

<sup>6</sup> <https://www.gmercyu.edu/academics/learn/become-a-clinical-nurse-specialist>.

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 3

most highly trained health care professional, physicians are the appropriate leaders of the health care team. The reality is that nonphysician practitioners do not have the education and training needed to be the head of the care team and our nation's Medicare and Medicaid patients deserve physician-led care.

Moreover, when nonphysician practitioners practice independently, the result is lower-quality, higher-cost care. For example, nonphysician practitioners tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and overprescribe antibiotics—all of which increase health care costs and threaten patient safety. There is strong evidence that increasing the scope of practice of nurse practitioners and physician assistants has resulted in increased health care costs. 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 practicing independently 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.<sup>7</sup> 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.<sup>8</sup> **The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for differences in salary.**<sup>9</sup> 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.

In addition, a recent study from the Hattiesburg Clinic in Mississippi found that allowing nurse practitioners and physician assistants 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.<sup>10</sup> 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 nonphysicians.

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.<sup>11</sup> Additionally, multiple

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<sup>7</sup> *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> <https://ejournal.msmaonline.com/publication/?m=63060&i=735364&view=contentsBrowser>.

<sup>11</sup> 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.

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 4

studies have shown that 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, ordering x-rays increased substantially—more than 400 percent—by nonphysicians, primarily nurse practitioners and physician assistants, between 2003 and 2015.<sup>12</sup> Furthermore, a Mayo Clinic study compared the quality of physician referrals for patients with complex medical problems against referrals from nurse practitioners and physician assistants for patients with the same problems. Physician referrals were better articulated, better documented, better evaluated, better managed, and were more likely to be evaluated as medically necessary than nurse practitioner or physician assistant referrals, which were more likely to be evaluated as having little clinical value.<sup>13</sup> This sampling of studies clearly shows that nurse practitioners and physician assistants tend to prescribe inappropriately and misuse health care resources, and are less able to manage complex medical problems<sup>14</sup>—all which increases health care costs, threatens patient safety, and leads to poorer health care outcomes.

Finally, it is important to ensure that certified registered nurse anesthetists are properly overseen. Anesthesia care is the practice of medicine. It is a highly time-dependent critical care-like service that demands the immediate availability of a physician's medical decision-making skills, especially for the Medicare patient population. The Medicare anesthesia supervision rule is an important standard that was created for the health and safety of Medicare beneficiaries and must be preserved for their well-being. The current rule represents a well-established and functional compromise approach to physician clinical supervision. The unique structure of the rule sets a minimum physician supervision standard, while giving flexibility to states to utilize higher levels of clinical oversight or to “opt-out” of the rule. 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.

Therefore, due to the increased education and training of physicians, the ability of physicians to more accurately treat and diagnose patients, the lack of additional access provided by expanding scope of practice laws, and the negative consequences of removing physicians from the care team, the undersigned organizations strongly oppose the I CAN Act. Congress should avoid advancing this sweeping bill that places patient safety at risk.

Sincerely,

American Medical Association  
American Academy of Cosmetic Surgery  
American Academy of Dermatology

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<sup>12</sup> D.J. Mizrahi, et.al. “National Trends in the Utilization of Skeletal Radiography,” Journal of the American College of Radiology 2018; 1408-1414.

<sup>13</sup> Lohr RH, West CP, Beliveau M, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings. 2013;88:1266-1271.

<sup>14</sup> 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.

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 5

American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)  
American Academy of Family Physicians  
American Academy of Ophthalmology  
American Academy of Otolaryngology-Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation  
American Association of Child and Adolescent Psychiatry  
American Association of Clinical Endocrinology  
American Association of Clinical Urologists  
American Association of Neurological Surgeons  
American College of Allergy, Asthma & Immunology  
American College of Emergency Physicians  
American College of Medical Genetics and Genomics  
American College of Osteopathic Internists  
American College of Radiology  
American Orthopaedic Foot & Ankle Society  
American Osteopathic Association  
American Psychiatric Association  
American Society for Aesthetic Plastic Surgery (The Aesthetic Society)  
American Society for Clinical Pathology  
American Society for Dermatologic Surgery Association  
American Society for Laser Medicine and Surgery  
American Society for Radiation Oncology  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of Echocardiography  
American Society of Neuroradiology  
American Society of Plastic Surgeons  
American Society of Retina Specialists  
American Vein & Lymphatic Society  
College of American Pathologists  
Congress of Neurological Surgeons  
International Society for Advancement of Spine Surgery  
International Society of Hair Restoration Surgery  
National Association of Medical Examiners  
North American Neuromodulation Society  
North American Spine Society  
Renal Physicians Association  
Society for Pediatric Dermatology  
Society for Vascular Surgery  
Society of American Gastrointestinal and Endoscopic Surgeons  
Society of Interventional Radiology  
Spine Intervention Society

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 6

Medical Association of the State of Alabama  
Alaska State Medical Association  
Arizona Medical Association  
Arkansas Medical Society  
California Medical Association  
Colorado Medical Society  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia  
Florida Medical Association  
Medical Association of Georgia  
Hawaii Medical Association  
Idaho Medical Association  
Illinois State Medical Society  
Indiana State Medical Association  
Iowa Medical Society  
Kansas Medical Society  
Kentucky Medical Association  
Louisiana State Medical Society  
Maine Medical Association  
MedChi, The Maryland State Medical Society  
Massachusetts Medical Society  
Michigan State Medical Society  
Minnesota Medical Association  
Mississippi State Medical Association  
Missouri State Medical Association  
Montana Medical Association  
Nebraska Medical Association  
Nevada State Medical Association  
New Hampshire Medical Society  
Medical Society of New Jersey  
New Mexico Medical Society  
Medical Society of the State of New York  
North Carolina Medical Society  
North Dakota Medical Society  
Ohio State Medical Association  
Oklahoma State Medical Association  
Pennsylvania Medical Society  
Rhode Island Medical Society  
South Carolina Medical Association  
South Dakota State Medical Association  
Tennessee Medical Association  
Texas Medical Association  
Utah Medical Association  
Medical Society of Virginia

The Honorable Jason Smith  
The Honorable Cathy McMorris Rodgers  
The Honorable Richie Neal  
The Honorable Frank Pallone  
June 1, 2023  
Page 7

Washington State Medical Association  
West Virginia State Medical Association  
Wisconsin Medical Society  
Wyoming Medical Society

cc: The Honorable David Joyce, United States House of Representatives  
The Honorable Suzanne Bonamici, United States House of Representatives