

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

involved in their diagnosis and treatment decisions.¹ 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.² 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.³ 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.⁴
- 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.⁵
- 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.⁶

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

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

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

³ 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.

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

⁵ *Id.*

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

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.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 differences in salary.**⁹ 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.¹⁰ 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.¹¹ Additionally, multiple

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

⁸ *Id.*

⁹ *Id.*

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

¹¹ 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.

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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 2015.¹² 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.¹³ 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 problems¹⁴—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

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

¹³ 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.

¹⁴ 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.

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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

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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

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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