November 2, 2022

The Honorable Richie Neal
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
1139 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

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

Dear Chairmen Neal and Pallone and Ranking Members Brady and McMorris Rodgers:

The undersigned medical professional organizations write to you in strong opposition to H.R. 8812, 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 non-physician practitioners (NPPs), including nurse practitioners (NPs), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNS), and physician assistants (PAs).

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 NPPs can perform and removing physician involvement in patient care. This legislation would allow NPPs 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 our patients. Additionally, this bill will remove supervision requirements for CRNAs, a change that could have devastating 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 NPPs 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 NPPs who practice at the top of their license within 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 will 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] Yet the I CAN Act effectively removes physicians

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

from important medical treatment decisions regarding a patient's care. Furthermore, despite claims to the contrary, expanding the scope of practice for NPPs does not increase patient access in rural or underserved areas. In reviewing the actual practice locations of primary care physicians compared to NPPs, it is clear that physicians and non-physicians tend to practice in the same areas of the state.[2] This is true even in those states where, for example, NPs 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 necessarily 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 NPPs 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]
- NPs, 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]
- PAs complete two to two and half years of graduate level education with only 2,000 hours of clinical care and no residency requirement.
- CRNAs complete two to three years of graduate level education, have no residency requirement, and complete only 2,500 hours of clinical training.
- CNMs 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.
- CNS complete a master's degree but there is no residency requirement and only 500 clinical hours of training are required.[6]

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. The reality is that NPPs do not have the education and training to make these determinations and we should not be offering a lower standard of care or clinical expertise for our nation's Medicare and Medicaid patients.

Moreover, NPPs overutilize services and unnecessarily increase costs by overprescribing, ordering more x-rays than are needed, and over engaging specialists. NPPs' overutilization can be seen through multiple examples, including the strong evidence that increasing the scope of practice of NPs and PAs has resulted in overuse of diagnostic imaging and other services. For example, in states that allow independent prescribing, NPs and PAs were 20 times more likely to overprescribe opioids than those in prescription-

[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.

restricted states. [7] Additionally, multiple studies have shown that NPs 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 non-physicians, primarily NPs and PAs, between 2003 and 2015.[8] In addition, a recent study from the Hattiesburg Clinic in Mississippi found that allowing NPs and PAs to function with independent patient panels under physician supervision 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.[9] Additionally, a Mayo Clinic study compared the quality of physician referrals for patients with complex medical problems against referrals from NPs and PAs 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 NP or PA referrals, which were more likely to be evaluated as having little clinical value.[10] This sampling of studies clearly shows that NPs and PAs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, overprescribe antibiotics, and are less able to understand and diagnose complex medical problems[11]—all which increase health care costs, threaten patient safety, and lead to poorer health care outcomes.

Finally, it is important to ensure that CRNAs 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 urge the Committees to oppose the I CAN Act.

Sincerely,

American Medical Association

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[7] 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.
[8] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.
[9] https://ejournal.msmaonline.com/publication/?m=63060&i=735364&view=contentsBrowser.
[10] 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.
[11] 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.

Academy of Consultation-Liaison Psychiatry
American Academy of Allergy, Asthma & Immunology
American Academy of Emergency Medicine
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation.
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Clinical Urologists
American Association of Neurological Surgeon
American College of Allergy, Asthma and Immunology
American College of Emergency Physicians
American College of Occupational and Environmental Medicine
American College of Osteopathic Internists
American College of Physicians
American College of Radiology
American College of Surgeons
American Medical Women's Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
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 Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Neuroradiology
American Society of Retina Specialists
American Vein & Lymphatic Society
College of American Pathologists
Congress of Neurological Surgeons
National Association of Spine Specialists
Society for Pediatric Dermatology
Society of Interventional Radiology

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 Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
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Michigan State Medical Society
Mississippi State Medical Association
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New Hampshire Medical Society
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North Dakota Medical Association
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Pennsylvania Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Cc: The Honorable Lucille Roybal-Allard
The Honorable David Joyce