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The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Bobby Scott
Ranking Member
Committee on Education and the Workforce
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Foxx and Ranking Member Scott:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in strong opposition to H.R. 618, the "Improving Access to Workers' Compensation for Injured Federal Workers Act." We are disappointed that the House Education and Workforce Committee is marking up this legislation that would allow nurse practitioners and physician assistants to diagnose, prescribe, treat, and certify an injury and extent of disability for purposes of compensating federal workers under the Federal Employees' Compensation Act (FECA). This legislation has been opposed by the AMA in multiple Congresses.

Current law prohibits non-physician health professionals from making determinations of federal worker injuries under FECA and reserves this function to physicians who have the necessary education, training, and expertise to make these evaluations. The AMA remains steadfast in its commitment to patients who have said repeatedly that they want and expect physicians to lead their health care team. In a recent survey of U.S. voters, 95 percent said that it is important for a physician to be involved in their diagnosis and treatment decisions. However, H.R. 618 effectively removes physicians from the care team and sets up our federal workers for suboptimal health outcomes and increased costs, without improving access to care. By providing our injured federal workers with access to health care professionals who possess a lower level of training, we run the risk that they will not receive the right care at the right time, incur greater health care costs, worse outcomes and remain injured and out of the workforce longer.

Education Matters: Patients Want Physicians Involved in Their Diagnosis and Treatment Decisions

The AMA is concerned that H.R. 618, while perhaps well-intentioned for speedier workers' compensation determinations, will actually jeopardize patient care and may slow down claims as many studies show that nurse practitioners and physician assistants tend to order more tests and seek more referrals, leading to delays in care. While the bill purports to allow nurse practitioners and physician assistants to diagnose, prescribe, treat, and certify an injury and extent of disability within their state scope of practice laws, the federal government dictating this scope expansion will have the effect of setting the benchmark for the states. We have seen this repeatedly with Medicare coverage determinations, for example, setting the benchmark for private plan coverage determinations. We also saw this following the passage of the Home Health Care Improvement Act as part of the CARES Act. This bill allowed non-physician practitioners to certify home health services for Medicare beneficiaries in accordance with state law. While the bill deferred to state law, we saw non-physicians in many states promoting legislation to expand their state

scope of practice laws for home health certification, urging state lawmakers that such legislation is necessary to align with the new expansions allowed at the federal level.

Moreover, while all health care professionals play a critical role in providing care to patients, and nurse practitioners and physician assistants are important members of the care team, their skillsets are not interchangeable with that 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 a three-to-seven-year residency program, including 12,000-16,000 hours of clinical training. By contrast, nurse practitioners complete only two to three years of post-graduate education, have no residency requirement, and must only complete 500-720 hours of clinical training. The current physician assistant education model is two years in length with only 2,000 hours of clinical care– and it includes no residency requirement. Patients expect the most qualified person—physician experts with unmatched training, education, and experience—to be diagnosing and treating injured federal workers and making often complex clinical determinations on the nature of an injury and extent of disability. Nurse practitioners and physician assistants do not have the education and training to make these determinations, and we should not be offering a lower standard of care to our federal workers who are injured.

But it is more than just the vast difference in hours of education and training; it is also the difference in rigor and standardization between medical school/residency and nurse practitioner and physician assistant programs that matter and must be assessed. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, 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. Nurse practitioner **programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of nurse practitioner programs grew by more than 30 percent with well over half of these programs offered mostly or completely online**, meaning less in-person instruction and hands-on clinical experience. In addition, many programs require students to find their own preceptor to meet their practice hours requirement, resulting in much variation among students' clinical experiences. Importantly, the physician assistant education model assumes that in practice, physician assistants will engage in supervision by, or in collaboration with, a physician. Our injured federal workers deserve better—they deserve and have a right to have physicians leading their health care team.

Increasing Scope of Practice of Nurse Practitioners and Physician Assistants Can Lead to Increased Health Care Costs

There is also strong evidence that increasing the scope of practice of nurse practitioners and physician assistants has resulted in increased health care costs. For example, a high-quality study published 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 Veteran's 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.[1] 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.[2] **The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for differences in salary.**[3] 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 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. 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 emergency department 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 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 Internal Medicine* found 3.8 percent of physicians (MDs/DOs) compared to eight 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 6.3 percent of nurse practitioners prescribed an opioid to at least 50 percent of patients.[4] **The study further found that nurse practitioners and physician assistants in states that allow independent prescribing were <u>20 times</u> more likely to overprescribe opioids than those in prescription-restricted states.**[5]

The findings are clear: nurse practitioners and physician assistants tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and seek more referrals compared to physicians[6]—all which increase health care costs, potentially delay access to care, and threaten patient safety. Before expanding the scope of practice of all nurse practitioners and physician assistants and

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[1] *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.
[2] Id.
[3] Id.
[4] 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.
[5] Id.
[6] 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.

essentially removing physicians from the care team, we encourage Congress to carefully review these studies. We believe you will agree that the results are startling and have significant impact on the assessment of risk to the health and welfare of patients, as well as the impact on the cost of health care in the United States.

Proponents of H.R. 618 cite recognition of nurse practitioners and physician assistants within the FECA as necessary in order to assist with diagnosing and treating patients who contract COVID-19 in the workplace. They claim that permitting nurse practitioners and physician assistants to diagnose and treat individuals suffering from COVID-19 injuries helps patients get back to work faster so they can continue to provide for their families. Yet, COVID-19, a virus that is already responsible for the death of over one million individuals just in the United States, is a complex disease with varying impacts based on patient co-morbidities. Furthermore, pre-existing conditions and other complicating health factors have a tremendous impact on whether vaccines and therapeutics are appropriate for patients who have contracted COVID-19. These complexities highlight the fact that physician experts are best suited to assess, diagnose, and treat patients in the FECA program. In addition, the rate of COVID-19 infections has plummeted precipitously since the early parts of the pandemic. Since the public health emergency expired more than a year ago, the COVID-19 response is no longer an acceptable rationale for such an egregious federal scope of practice expansion that will undoubtedly serve as a precursor to even further inappropriate scope changes at the state level. Moreover, diagnosing and treating patients with COVID-19 is incomparable to the range and complexity of injuries and disabilities injured federal workers may face and that H.R. 618 would allow nurse practitioners and physician assistants to certify, particularly since such determinations have a direct impact on the course of treatment and care provided to injured federal workers, as well as the cost to the federal government.

Scope Expansions Have Not Proven to Increase Access to Care in Rural Areas

Proponents of scope expansion have argued that legislation like H.R. 618 is necessary to expand access to care. This promise has been made for years by nurse practitioners and physician assistants seeking scope expansions at the state-level, but it has not proven true. In reviewing the actual practice locations of primary care physicians compared to nurse practitioners and physician assistants, it is clear that physicians and non-physicians tend to practice in the same areas of the state. This is true even in those states where, for example, nurse practitioners can practice without physician involvement. The Graduate Nurse Demonstration Project (the Project), conducted by the Centers for Medicare & Medicaid Services, confirmed this as well.[7] One goal of the Project was to determine whether increased funding for advanced practice registered nursing (APRN) programs would increase the number of APRNs practicing in rural areas. The results found that this did not happen. In fact, only 9 percent of alumni from the program went on to work in rural areas.

Moreover, workforce studies in various states have shown a growing number of nurse practitioners are not entering primary care. For example, the Oregon Center for Nursing found only 25 percent of nurse practitioners practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the nurse practitioner workforce in New York that found, "[w]hile the vast majority of nurse practitioners report a primary care specialty certification, about one-third of active nurse practitioners are considered primary care nurse practitioners, which is based on both nurse practitioners specialty certification and practice setting." In addition, the study found newly graduated nurse practitioners were

[7] 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.

more likely to enter specialty or subspecialty care rather than primary care.[8] **In short, the evidence is clear that expanding scope for nurse practitioners and physician assistants will not necessarily lead to better access to care in rural America.**

Rather than support an unproven path forward, Congress should consider proven solutions to increase access to care, including supporting physician-led team-based care. Evidence shows that states that require physician-led team-based care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice. The Congressional Budget Office estimates the cost of this legislation is zero and includes in its assumptions that while some workers may get services more quickly, increasing costs to the federal government, that these workers might also return to work more quickly saving the federal government money for a net cost of zero. However, this analysis fails to take into account the cost to the health care system when patients do not receive the right care at the right time. Eliminating physicians from workers' compensation determinations increases this probability exponentially and is a gamble with the health of our federal workers that Congress should not be willing to take.

Conclusion

For all the reasons above, we strongly encourage you to protect the health and safety of our injured federal workers and oppose passage of H.R. 618 out of Committee.

Sincerely,

James L. Madara, MD

[8] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017.