AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Nancy Pelosi
H-232, The Capitol
United States House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
H-204, The Capitol
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Minority Leader McCarthy:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in strong opposition to H.R. 6087, the "Improving Access to Workers' Compensation for Injured Federal Workers Act." This legislation would allow nurse practitioners (NPs) and physician assistants (PAs) 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).

Current law prohibits non-physician health professionals from making these determinations and reserves this function to physicians who have the 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 leading their health care team. In a recent survey of U.S. voters, 68% say it is very important for a physician to be involved in their diagnosis and treatment decisions. However, H.R. 6087 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. At a time when inflation is at an all-time high and our economy is still struggling to recover from the costs associated with the COVID-19 pandemic, now is especially not the time for Congress to enact this type of policy change.

Education Matters: Patients want physicians involved in their diagnosis and treatment decisions

The AMA is concerned that H.R. 6087, while perhaps well-intentioned for speedier workers' compensation determinations, will actually jeopardize patient care. While the bill purports to allow NPs and PAs 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. Moreover, while all health care professionals play a critical role in providing care to patients, and NPs and PAs 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 10,000-16,000 hours of clinical training. By contrast, NPs, complete only two to three years of education, have no residency requirement, and only 500-720 hours of clinical training. The current PA education model is two years in length with only 2,000 hours of clinical care and 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. NPs and PAs 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 NP and PA 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. **NP programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of NP programs grew by more than 30%, 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. 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 NPs and PAs can lead to increased health care costs

There is strong evidence that increasing the scope of practice of NPs and PAs has resulted in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services. For example, a 2020 study published in the *Journal of Internal Medicine* found 3.8% of physicians (MDs/DOs) compared to 8.0% of NPs met at least one definition of overprescribing opioids and 1.3% of physicians compared to 6.3% of NPs prescribed an opioid to at least 50% of patients.[1] **The study further found that, in states that allow independent prescribing, NPs were 20 times more likely to overprescribe opioids than those in prescription-restricted states.**[2]

Multiple studies have also 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, a study in the *Journal of the American College of Radiology*, which analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—**more than 400%**—by non-physicians, primarily NPs and PAs, during this time frame.[3] A separate study published in *JAMA Internal Medicin*e found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a

[1]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.
[2] Id.
[3] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.

referral to a specialist.[4] **The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding NP scope of practice alone.**

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. Specifically, the study found that non-nursing home Medicare ACO patient spend was $43 higher per member, per month for patients on a NP/PA panel compared to those with a primary care physician. Similarly, patients with an NP/PA as their primary care provider were 1.8% more likely to visit the ER and had an 8% 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 9 of the 10 measures compared to the non-physicians.

The findings are clear: NPs and PAs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and overprescribe antibiotics[5]—all which increase health care costs and threaten patient safety. The Hattiesburg Clinic study further confirms these findings and the need for physician-led team-based care. Before expanding the scope of practice of all NPs and PAs and 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.

Finally, proponents of H.R. 6087 cite recognition of NPs and PAs 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 NPs and PAs to diagnose and treat individuals suffering from COVID-19 injuries is believed to help 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 be assessing, diagnosing, and treating patients in the FECA program.

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[4] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.

[5] 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.

Scope expansions have not proven to increase access to care in rural areas

Proponents of scope expansion have argued that legislation like H.R. 6087 is necessary to expand access to care. This promise has been made for years by NPs and PAs 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 NPs and PAs, 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, NPs can practice without physician involvement. The Graduate Nurse Demonstration Project (the Project), conducted by the Centers for Medicare & Medicaid Services, confirmed this as well.[6] One goal of the Project was to determine whether increased funding for Advanced Practice Registered Nursing (APRNs) programs would increase the number of APRNs practicing in rural areas. The results found that this did not happen. In fact, only 9% of alumni from the program went on to work in rural areas.

Moreover, workforce studies in various states have shown a growing number of NPs are not entering primary care. For example, the Oregon Center for Nursing found only 25% of NPs practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the NP workforce in New York that found, "[w]hile the vast majority of NPs report a primary care specialty certification, about one-third of active NPs are considered primary care NPs, which is based on both NP specialty certification and practice setting." In addition, the study found newly graduated NPs were more likely to enter specialty or subspecialty care rather than primary care.[7] **In short, the evidence is clear that expanding scope for NPs and PAs will not necessarily lead to better access to care in rural America.**

Rather than supporting 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 NPs 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 likelihood exponentially and is a gamble with the health of our federal workers that Congress should not be willing to take.

Enactment under suspension of the House rules is inappropriate

The AMA is also concerned that the House of Representatives is attempting to pass H.R. 6087 under "suspension of the rules," a procedural tactic that is often used to act expeditiously on legislation that is typically non-controversial. Bills considered "under suspension" receive limited floor debate, all floor amendments are prohibited, and a two-thirds vote of all members present is required for final passage.

H.R. 6087 does not meet the definition of a "non-controversial" bill and, therefore, should not be considered under suspension of the rules. First and foremost, the strong concerns we raise in this letter

[6] 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.
[7] 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.

should be sufficient for lawmakers to recognize that legislation that would be detrimental to the health and welfare of federal workers should not be considered under this fast-track parliamentary procedure. While it passed out of the House Education and Labor Committee in mid-March 2022, H.R. 6087 was formally introduced two months ago and has only generated 18 total cosponsors. Bills enacted under suspension of the rules typically garner hundreds of cosponsors, thus indicating a high level of bipartisan support. It is unclear whether a strong collection of bipartisan members of the House of Representatives support this legislation that inappropriately expands non-physician practitioner scope of practice. While the AMA opposes final passage of this legislation, we urge the House of Representatives to reject enactment of this bill under suspension of the rules.

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. 6087.

Sincerely,

James L. Madara, MD

cc: The Honorable Joe Courtney
The Honorable Tim Walberg