AMA
AMERICAN MEDICAL ASSOCIATION

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February 5, 2021

The Honorable Hob Bryan
Chairman
Senate Public Health and Welfare Committee
Mississippi State Senate
P.O. Box 1018
Jackson, MS 39215

Re: **AMA Opposition to H.B. 1303**

Dear Chair Bryan:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to express our **strong opposition to House Bill (H.B.) 1303**, which would allow all Advanced Practice Registered Nurses (APRNs) the ability to provide medical care without any physician involvement. This legislation also sets a dangerous precedent by allowing nurse practitioners, one type of APRN, to provide oversight of other APRNs, including certified registered nurse anesthetists, nurse midwives, and clinical nurse specialists, without any education or training in these specialized areas of care. Such a move is not permitted in any other state and sets Mississippi on a crash course toward worsening health outcomes and higher costs.

The AMA is deeply concerned that H.B. 1303 threatens the health and safety of patients in Mississippi by allowing all APRNs to practice without any physician supervision, collaboration, or oversight. While all health care professionals play a critical role in providing care to patients and all APRNs are important members of the care team, their skillsets are not interchangeable with that of fully trained physicians. This is fundamentally evident based on the difference in education and training. Physicians complete four years of medical school plus a three-seven-year residency program, including 10,000-16,000 hours of clinical training. By contrast, nurse practitioners complete only two to three years of education, have no residency requirement and only 500-720 hours of clinical training. Certified registered nurse anesthetists, another type of APRN, have only two to three years of education, no residency requirement and approximately 2,500 hours of clinical practice. 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 APRN programs. 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 and other APRN programs do not have similar time-tested

standardizations. They are not trained to practice independently. Patients in Mississippi deserve to have physicians leading their health care team.

Additionally, the AMA believes H.B. 1303 takes Mississippi's health care in a dangerous direction by allowing nurse practitioners to serve as the collaborating/consulting provider for other categories of APRNs: certified registered nurse anesthetists, nurse midwives and clinical nurse specialists. **This is not permitted in any other state and fails to recognize the distinct difference in education and training among the different types of APRNs and compared to physicians**. As discussed above, there are four types of APRNs, nurse practitioners, certified registered nurse anesthetists, nurse midwives, and clinical nurse specialists. All have a separate and unique focus and different paths for education, training, and certification. Nurse practitioners do not have the education and training to practice without physician supervision themselves and certainly do not have the education and training to supervise other APRNs beyond their own scope.

APRNs are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.

Patients agree—98% of Mississippians believe that physicians and nurse practitioners need to work in a coordinated manner to ensure that patients get the care they need. All members of the health care team serve an important role in health care and are valuable members of the care team, but they are not a replacement for physicians.

There is also strong evidence that H.B. 1303 will result in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services by nurse practitioners. Studies have shown nurse practitioners tend to prescribe more opioids than physicians. In states that allow independent prescribing, nurse practitioners were **20 times** more likely to overprescribe opioids than those in prescription-restricted states.[1] Multiple studies have also 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, 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 nurse practitioners and physician assistants during this time frame.[2] A separate study published in *JAMA Internal Medicin*e found nurse practitioners 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] 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.[3] **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 nurse practitioner scope of practice alone.**

Data from Hattiesburg Clinic in Mississippi confirmed these findings on cost and referrals and also found physicians scored higher in quality metrics compared to advanced practice providers (APPs). After 10 years of data comparing primary care panels of patients led by APPs (with physician supervision) and primary care panels of patients led by physicians, the Clinic found physicians performed better than APPs in 9 of 10 quality metrics. They also found the cost was $43 higher per member per month for patients seen by an APP compared to physician—and $119 higher when adjusted for patient complexity. Furthermore, APPs had an 8 percent higher referral rate to specialists compared to primary care physicians. Finally, patients seen by an APP were also more likely to visit the ER despite the fact they were younger and healthier as a group compared to patients seen by physicians. Hattiesburg Clinic will continue using APPs, as they are an integral part of the care team, however, among other changes, "APPs will no longer be permitted to have panels of their own" as a result of these findings.

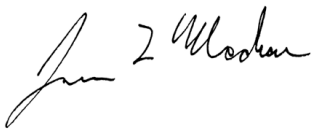
Proponents of H.B. 1303 have argued this legislation is necessary to expand access to care. This promise has been made in many other states, but it has not proven true. In reviewing the actual practice locations of primary care physicians compared to nurse practitioners and other APRNs, it is clear, that physicians and APRNs tend to practice in the same areas of the state. This is true even in those states where nurse practitioners can practice without physician involvement. The Graduate Nurse Demonstration Project, conducted by the Centers for Medicare & Medicaid Services, confirmed this as well. One goal of the program was to determine whether increased funding for APRN 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 nurse practitioners are not entering primary care. For example, the Oregon Center for Nursing found only 25% of nurse practitioners practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the nurse practitioner workforce in New York, finding "[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 nurse practitioners were more likely to enter specialty or subspecialty care rather than primary care. In short, the evidence is clear that expanding scope for APRNs will not necessarily lead to better access to care in rural Mississippi.

Rather than support an unproven path forward, legislators should consider proven solutions to increase access to care, including supporting physician-led team-based care. Evidence shows, 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. Other proven reforms include Mississippi's rural physician scholarship program, which will result in more than 200 new physicians in rural areas of the state by 2030, and telehealth expansion which the legislature is also considering this session. These proven solutions ensure all Mississippians have access to high quality health care.

[3] 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.

For all the reasons above, we strongly encourage you to protect the health and safety of patients in Mississippi and oppose H.B. 1303. Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,



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