AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 14, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, we write in response to the request dated December 26, 2019 for additional feedback to part of the President's Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation's Seniors.

The EO directs HHS to propose a number of reforms to the Medicare program, including ones that eliminate supervision and licensure requirements of the Medicare program that are more stringent than other applicable federal or state laws.

The AAFP implores CMS to continue to base scope of practice regulations and program guidance of health care professionals on standardized training criteria and demonstrated experience and competence in patient care. Furthermore, we believe that state governments and their medical boards are better positioned to make these determinations and administer oversight of health care professionals in their respective states.

The AAFP strongly supports agency efforts to reduce administrative burdens throughout the Medicare and Medicaid programs, consistent with a letter sent October 29, 2019 by national and state physician organizations, but the AAFP must strongly oppose the broad yet vague language in section 5 of EO #13890 lifting supervision requirements of nonphysician providers.

While all health care professionals share an important role in providing care to patients, their skills are not interchangeable with those of a fully trained physician, and this is especially true in family medicine and primary care. Advanced practice registered nurses (APRNs) and physician assistants (PAs) are valuable health care clinicians whose scope of practice should correspond to, but not exceed, their level of knowledge, skill, experience, training (using competency training measures), and licensure. APRNs and PAs should never independently deliver care without supervision from a physician.

While physicians, APRNs, and PAs all must complete a four-year bachelor's degree, the amount of education and clinical care post-bachelor's varies widely. Physicians complete four years of medical school while APRNs complete one and a half to three years of masters-level coursework and PAs complete three years of graduate-level training. In addition, physicians complete a minimum of three years of residency including 12,000 to 16,000 hours of clinical

patient care. The clinical patient care requirement for APRNs and PAs ranges from 500 to 2,000 hours. Family Physicians undergo rigorous primary care specific Board Certification and testing on a continuous basis and are required to obtain 150 credits of continuing medical education (CME) every three years. The continuing education and certification requirements for APRNs PAs are much less. Physicians are required by law to carry their own medical liability insurance while APRNs and PAs are not. For these reasons, an APRN or PA is not a substitute, nor are they interchangeable for a physician when it comes to ensuring patient safety or high-quality care. This is especially true for patients in a primary care setting who often present with a set of undifferentiated signs and symptoms and/or multiple chronic conditions.

While some organizations have suggested allowing APRNs and PAs to practice independently could solve our nation's current access to care and cost of care dilemmas, health care trends in states that have allowed such expanded and unrestricted practice clearly disprove these claims. Since 1973, Washington state nurse practitioners have practiced on par of that with primary care physicians yet according to a Kaiser Family Foundation study, during the 20-year period from 1993 to 2013, per capita spending in Washington increased from $2,751 to $7,609. By comparison, the United States per capita spending average increased from $2,996 to $7,703 during the same period. Thus, per capita spending in Washington increased from 92% to 99% of the national average.

Regarding whether independent practice by nurses has addressed Washington state's access issues, the Health Resources and Services Administration, found that Washington -- a state with 39 counties -- has 27 geographic health professional shortage areas for primary care despite this expanded scope of practice by APRNs.

No patient, especially those in rural and underserved areas, should be relegated to a lower level of care by clinicians with lesser training by virtue of their zip code, therefore the AAFP opposes allowing APRNs or PAs the ability to independently provide patient care or other unsupervised services with no physician supervision/collaboration.

Additionally, research from *Infection Control and Hospital Epidemiology* reported that adult patients with common upper respiratory conditions that should not require antibiotics were 15% more likely to get an antibiotic when seen by nurse practitioners. A *JAMA Internal Medicine* study found that, compared to primary care physicians, nurse practitioners ordered more diagnostic imaging—particularly x-rays—for both new and established patients. The findings suggest that expanding the authority and use of nurse practitioners can expose patients to inappropriate prescriptions and x-rays, add unnecessary costs to the patient, risk exacerbation of bacterial resistance, and threaten unnecessary radiation exposure.

It is the AAFP's longstanding policy on team-based care to encourage health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician. Advanced primary care practices represent an ideal example of an integrated practice arrangement in which a licensed physician (MD/DO) works with other health care personnel to manage the care of an individual patient and a population of patients using a multidisciplinary, collaborative approach to health care. The arrangement should support an interdependent, team-based approach to comprehensive care delivery. It should address patient needs for high-value, accessible health care and be supported by enhanced communication and processes

that empower non-physician staff to effectively utilize the skills, training and abilities of each team member to the full extent of their training, experience and professional capacity.

As the agency explores ways to address high health care costs and improve access to care, the AAFP urges careful consultation with the Academy's value-based payment policy. Value-based payment (VBP) is a concept by which purchasers of health care and payers hold the health care delivery system at large accountable for both quality and cost of care. VBP uses alternative payment models (APMs) or pay-for-performance (PFP) arrangements to create a combination of incentives and disincentives intended to encourage better health care decision making by tying compensation to certain performance measures. Critical to value-based payment is providing appropriate, cost effective care. Due to their comprehensive training, family physicians have the expertise to deliver care in the primary care setting, where APRNs or PAs would more likely refer to higher-cost specialty care due to their more limited education, experience and training.

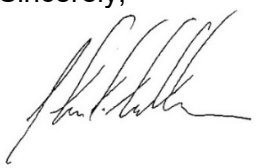
Only care teams with appropriate physician supervision address patients' needs for high quality, accessible health care and reflect the skills, training, and abilities of each of the team members to the full extent of their state-based licenses. **Family physicians are particularly qualified to lead the health care team because they possess the skills, training, experience, knowledge, and leadership needed to provide comprehensive medical care, health maintenance, and preventive services for a range of medical and behavioral health issues.** Family medicine is focused on the whole person including the biological, clinical, and behavioral sciences, encompassing all ages, sexes, each organ system, and every disease entity. APRNS and PAs, while a part of the care team, do not have the education, training and experience to carry out the comprehensive scope of a family physician.

Physicians, APRNs, and PAs occupy different roles in the delivery of high-quality, comprehensive health care. The AAFP recognizes that both APRNs and PAs are an integral and valuable part of a physician-led team. However, we believe that independent practice and prescribing for APRNs and PAs is not the answer. Physicians offer an unmatched service to patients and, without their skills, patients' safety would be at risk. We strongly urge you to not expand APRN and PAs scope of practice, as it would fundamentally diminish the standard of care for patients and dismantle the physician-led team-based care model in Medicare and Medicaid.

Given family physicians' extensive education and training, we believe patient safety and quality of care are best served by ensuring that the services provided by APRNs and PAs continue to be delivered with the supervision of a physician.

Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 or rbennett@aafp.org with any questions.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair