June 6, 2023

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

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

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
2125 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

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

Dear Chairs Smith and McMorris Rodgers and Ranking Members Neal and Pallone,

The undersigned organizations write in support of H.R. 2713, *The Improving Care and Access to Nurses (ICAN) Act* and to address misinformation that has been raised regarding the legislation. This letter is also accompanied by a letter of support for the ICAN Act that is signed by more than 235 organizations, representing a broad coalition of health care stakeholders.

H.R. 2713 would remove barriers to practice within the Medicare and Medicaid programs that restrict the ability of advanced practice registered nurses (APRNs) to practice to the full extent of their education and clinical training. This legislation is consistent with the recommendation from numerous organizations, including the National Academy of Medicine (NAM), which urged that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[1] As of 2021, over 250,000 APRNs treated Medicare patients and over 40% of Medicare beneficiaries received care from an APRN. These beneficiaries deserve full access to medically necessary covered services provided by APRNs without facing unnecessary burdens. We appreciate your consideration of this letter and the ICAN Act, and your consistent support for APRNs and their patients.

APRNs are Clinically Trained and Qualified to Provide These Services

We would also like to take this opportunity to directly address the misinformation that has been raised regarding this legislation. First, APRNs are educated, clinically trained and qualified to provide these services. APRNs include nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), and clinical nurse specialists (CNSs), and all play a pivotal role in our current and future health care system. APRNs are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds, and in all settings. APRNs are educated under the nursing model, where clinical training is integrated into their core curriculum. APRN programs are competency-based, not time-based. A student must demonstrate mastery of content before advancing. While the nursing and medical models of training are different, the safety and quality of APRN competency-based education is consistently demonstrated in more than 40 years of patient care research, studies which we would be more than happy to provide the Committees. For example, the American Enterprise Institute released a report that found that "beneficiaries who

[1] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf

received their primary care from NPs consistently received significantly higher-quality care than physicians' patients in several respects. While beneficiaries treated by physicians received slightly better services in a few realms, the differences were marginal."[2] The yardstick of educational effectiveness should be based on patient outcomes, and decades of research demonstrate the high-quality care provided by APRNs.

The ICAN Act Does not Expand Scope of Practice for APRNs

Second, the ICAN Act does not expand scope of practice for APRNs. The ICAN Act does remove outdated federal barriers within the Medicare and Medicaid programs to increase patient access to services provided by APRNs. All APRNs providing care within the Medicare and Medicaid programs must practice in accordance with state law, and the ICAN Act does not change this policy. This legislation addresses areas within the Medicare and Medicaid programs where APRNs are prevented from practicing to the full extent of their education, clinical training and state scope of practice, thus limiting their patients' access to medically necessary covered Medicare and Medicaid services. For example, contrary to claims made by medical organizations, Section 401 would not supersede state scope of practice. It would ensure that Local Coverage Determinations (LCDs) do not contain language that limit or deny a provider who is qualified and acting within the scope of that provider's state license and certification. Medicare and Medicaid patients who receive care from APRNs should not be required to jump through additional hoops to access medically necessary covered services.

APRNs Increase Healthcare Access in Rural and Underserved Communities

Third, removing these barriers to practice on APRNs will increase access to care in rural and underserved communities. Below are several independent studies and reports that demonstrate this point. However, medical organizations continue to make contrary assertions in opposition to the ICAN Act and other legislation and regulatory proposals. For instance, in response to a recent Centers of Medicare and Medicaid Services (CMS) proposal to authorize APRNs to supervise diagnostic tests in hospital outpatient settings, medical organizations argued that the proposal would not increase access to care, using the same data points that they provided to Members of Congress in response to the ICAN Act. Ultimately, CMS finalized the authorization for APRNs to supervise diagnostic tests as proposed. In the final rule, CMS stated that the agency did not agree with the claim that APRNs would not increase access to care and that the evidence provided was insufficient to support this contention. The ICAN Act includes common sense reforms that will reduce barriers to care so that all patients, especially those in rural and underserved areas, have timely access to care. Examples of the impact APRNs have in rural and underserved areas include the following:

- According to the Medicare Payment Advisory Commission (MedPAC), APRNs and Physician Assistants (PAs) comprise approximately one-third of the primary care workforce, and up to half in rural areas.[3] MedPAC's 2022 survey also found that rural and lower-income beneficiaries were more likely to report getting most or all of their primary care from an NP or PA compared with middle-income and higher-income beneficiaries.[4]
- MedPAC also found that, among all clinician types, NPs had the highest share of allowed charges associated with low-income subsidy Medicare beneficiaries.[5]
- An American Enterprise Institute (AEI) study titled *Nurse Practitioners: A Solution to Americas Primary Care Crisis* found that NPs "are significantly more likely than primary care physicians to

[2] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[3] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2).
[4] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf (Page 145). page 133).
[5] *Ibid.* at page 135.

care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[6]

- According to a Government Accountability Office report on rural hospital closures "from 2012 to 2017, the availability of all physicians declined more among counties with [rural hospital] closures (16.2 percent) compared to counties without closures (1.3 percent)" whereas "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[7]
- After the passage of the *Comprehensive Addiction and Recovery Act of 2016* (CARA), studies have found that NPs increased access to MAT in rural and underserved communities. For instance, one study found that NPs and PAs were the first waivered providers in hundreds of rural counties, representing millions of individuals.[8] The Medicaid and CHIP Payment and Access Commission found that the number of NPs prescribing buprenorphine for the treatment of OUD, and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year they were authorized to obtain their Drug Addiction and Treatment Act (DATA) waiver, particularly in rural areas and for Medicaid beneficiaries.[9]
- A recent study published in *Health Affairs* found that from 2011-2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162%, compared to a 6% drop in psychiatrists during that same period. The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5% to 29.8% during that same period, exceeding 50% in rural, full practice authority regions.[10]
- CRNAs also are the predominant anesthesia providers in underserved areas and are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries when compared with physician counterparts.[11] Research evaluating type of facility, size, and anesthesia staffing by rural location shows that 55.5% of small rural hospitals and 61.2% of rural ambulatory surgery centers were predominately staffed by CRNAs.

APRNs Provide High-Quality Health Care

Fourth, decades of evidence demonstrate that APRNs provide high-quality, cost-effective health care with high patient satisfaction. The body of literature supports the position that APRNs provide care that is safe, effective, patient centered, efficient, equitable and evidence based. Examples of this research include:

- Numerous peer-reviewed studies have shown that CRNAs are safe, high quality and cost-effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a 2010 study published in the journal Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers

[6] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/.
[7] https://www.gao.gov/assets/gao-21-93.pdf.
[8] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859.
[9] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/.
[10] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289
[11] Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270.
http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx.

or by anesthesia delivery model.[12] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.[13] More recently, a study published in Medical Care (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[14]

- A recent study utilizing VA data from FY 2013 found significant savings, 6-7% lower costs, for highly complex diabetic patients who had an NP as their primary provider compared to those with a physician.[15] Other researchers found even greater savings, 12-13% lower costs when examining diabetic patients with varying degrees of complexity served by the VA. For a single VAMC this equated to an annual savings of just over 14 million dollars exemplifying the efficiency and effectiveness of NP delivered care in the VA.[16]
- Meta-analysis of studies comparing the quality of primary care services of physicians and NPs demonstrates the role NPs play in reinventing how primary care is delivered. The authors found that comparable outcomes are obtained by both providers, with NPs performing better in terms of time spent consulting with the patient, patient follow ups and patient satisfaction.[17]
- The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction; patient perceived health status; functional status; hospitalizations; emergency department visits; and biomarkers such as blood glucose, serum lipids and blood pressure. Newhouse, et al., conclude that NP patient outcomes are comparable to those of physicians.[18]

Broad Support for Removing Practice Barriers for APRNs

Fifth, there is broad support for removing barriers to practice on APRNs. In 2010 the Institute of Medicine (IOM) issued *The Future of Nursing: Leading Change, Advancing Health* report, which called for the removal of laws, regulations, and policies that prevent APRNs from providing the full scope of health care services they are educated and trained to provide. As noted above, this position was reaffirmed by the National Academy of Medicine (previously the IOM) in their 2021 *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report**.** The World Health Organization's *State of the World's Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, noting the positive impact it would have on addressing health care disparities and health care access within vulnerable communities.[19] A 2022 Morning Consult poll found that 82% of patients support authorizing NPs to

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[12] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[13] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[14] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[15] 10.1377/hlthaff.2019.00014HEALTH AFFAIRS 38, NO. 6 (2019): 1028–1036

[16] Rajan, et. al 2021 "Health care costs associated with primary care physicians versus nurse practitioners and physician assistants". https://pubmed.ncbi.nlm.nih.gov/34074952/

[17] Naylor, M.D. and Kurtzman, E.T. (2010). The Role of Nurse Practitioners in Reinventing Primary Care. *Health Affairs*, (5), 893-99.

[18] Newhouse, R.P., Stanik-Hutt, J., White, K.M., Johantgen, M., Bass, E.B., Zangaro, G., Wilson, R.F., Fountain, L., Steinwachs, D.M., Heindel, L., & Weiner, J.P. (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. *Nursing Economics***,** *29*(5), 1-22

[19] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf

practice to the full extent of their education and clinical training.[20] These recommendations have been echoed by bipartisan stakeholders such as the American Enterprise Institute[21] and the Brookings Institution[22], have received bipartisan support from multiple administrations,[23],[24] and the Federal Trade Commission has highlighted how barriers to practice on APRNs are unnecessary and limit competition.[25]

The purpose of this bill is to increase access, improve quality of care, and lower costs in the Medicare and Medicaid programs by removing federal barriers to practice for APRNs, consistent with the recommendations of NAM and other bipartisan stakeholders. The ICAN Act will move our nation's health care system forward in an effective and efficient manner that will benefit patients and clinicians.

We appreciate your consideration of this legislation and would welcome further conversation on any of the points raised in this letter, or otherwise. Should you have further questions, please contact MaryAnne Sapio, Vice President of Federal Government Affairs, American Association of Nurse Practitioners, Matt Thackston, Director, American Association of Nurse Anesthesiology, Federal Government Affairs, Sam Hewitt, Principal, Federal Affairs, American Nurses Association, or Amy Kohl, Director of Advocacy and Government Affairs, American College of Nurse-Midwives.

Sincerely,

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William Bruce, MBA, CAE
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American College of Nurse-Midwives

Cc: The Honorable David Joyce
The Honorable Susan Bonamici
The Honorable Jennifer Kiggans
The Honorable Lauren Underwood

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[20] https://connectwithcare.org/wp-content/uploads/2022/04/Telehealth_MC-Branded_PPT_Final.pdf.
[21] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/.
[22] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[23] https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-22073.pdf (see Section 5).
[24] https://www.healthaffairs.org/do/10.1377/forefront.20220404.728371/. (ACO REACH also includes a nurse practitioner services benefit enhancement designed to reduce barriers to care access, particularly for individuals with limited access to physicians. Through waivers, this strategy would allow nurse practitioners to certify patient needs (for example, for hospice) and order and supervise certain services (for example, cardiac rehabilitation).
[25] https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.