

# MEDICAL SOCIETY OF THE STATE OF NEW YORK



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Members of the MRT Work Group on Workforce Flexibility and Scope of Practice:

I would like to take this opportunity to reiterate medicine's support for the creation of a separate structure and process for review of the scope of practice expansion proposals which have been presented. In particular, I refer to items 77, 45, 46, 47, and 53. The proponents of each these initiatives have cited studies to support their contention that implementation of one or more of these items will reduce cost and improve quality of patient care. I have appended several studies which refute these claims. I do so to demonstrate the importance of further analysis of these proposals by clinicians and fiscal experts. Creation of a separate structure is essential to the appropriate review and deliberation of these complex and extremely far-reaching proposals.

Specifically, with regard to nurse practitioners, the proponents of independent practice for NPs argue that such a policy change would result in reduced health spending, presumably because NPs earn less than physicians. The Cochrane review suggests that this differential may be offset by increased utilization of services and referrals by NPs. This assertion was confirmed in a study by the American College of Physicians that compared utilization rates among physicians, residents, and nurse practitioners in the *Journal Effective Clinical Practice*. "Researchers showed that utilization of medical services was higher for patients assigned to nurse practitioners than for patients assigned to medical residents in 14 of 17 utilization measures, and higher in 10 of 17 measures when compared with patients assigned to attending physicians. The patient group assigned to nurse practitioners in the study experienced 13 more hospitalizations annually for each 100 patients and 108 more specialty visits per year per 100 patients than the patient cohort receiving care from physicians". *The Question of Independent Diagnosis and Prescriptive Authority for Advanced Practice Registered Nurses in Texas: Is the Reward Worth the Risk?* Ramos, 2011.

The same can be said for the proposal which would significantly expand the podiatric scope of practice. One study confirmed that while podiatrists may charge less on an individual service basis, "podiatrists performed substantially more procedures per episode of care and treated patients for longer periods, resulting in 43% higher total charges per episode". *Differences In Costs of Treatment For Foot Problems Between Podiatrists and Orthopedic Surgeons*, Harris, 1994.

Similarly, changing the Anesthesia care model puts patients at risk and will not save money. New York State is experiencing unprecedented safe anesthesia care as a result of advances in medical knowledge and anesthesiologist training, implementation of American Society of Anesthesiologists' practice guidelines which establish best practice standards, better drugs, safer equipment, and anesthesiologists unconditionally accepting their medical and legal responsibilities in the delivery of anesthesia care as mandated by the New York State Health Code (including the supervision of nurse anesthetists). There are no cost savings if nurse anesthetists practice independently. Under Medicare, the reimbursement for an anesthesia service is the same whether the services are provided by an anesthesiologist, an anesthesiologist medically directing a nurse anesthetist, or a nurse anesthetist supervised by the operating physician. When an anesthesiologist medically directs a nurse anesthetist, the fee is divided equally between the two providers. When a surgeon supervises a nurse anesthetist, the surgeon does not receive any portion of the anesthesia fee; the full amount goes to the nurse anesthetist or his or her employer. In addition, anesthesiologists are able to perform services that are included in the anesthesia fee that would have to be performed and billed by other physicians if the hospital chose to utilize nurse anesthetists rather than anesthesiologists. Moreover, in a study of Texas Medicaid Program costs associated with labor anesthesia, the average time per case was significantly higher for CRNAs (146 minutes) than for anesthesiologists. The CRNA cost to Medicaid was 19% more per claim than was the cost of anesthesiologists. *Influence of the Type of Anesthesia Provider On Costs Of Labor Analgesia To The Texas Medicaid Program, Abouleish, 2004.*

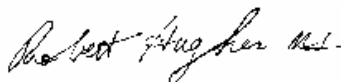
Contrary to the perspective of the proponents of these scope of practice expansions, States that have granted NPs the authority to independently diagnose patients and prescribe pharmaceuticals for treatment have not experienced significant migrations of NPs into underserved regions. As I mentioned in my remarks yesterday, the American Medical Association has conducted extensive geographic distribution studies in all 50 states, concluding that NPs and physicians tend to distribute in the same patterns, regardless of the states' levels of supervisory safeguards on the practice of medicine by NPs. Evidence of these similar practice patterns is demonstrated in AMA geographic distribution maps for Utah, Oregon, Idaho and Arizona on page six in the attached article entitled *Independent Diagnosis and Prescriptive Authority for Advanced Practice Registered Nurses in Texas: Is the Reward Worth the Risk?* Ramos, 2011. Each of these states has allowed NPs to diagnose and prescribe without collaboration. Practice distribution patterns between the NPs and physicians are very similar.

Moreover, despite the perspective of several members of this Work Group that advanced practice nurses and physician assistants will help address the workforce shortage problems now plaguing underserved regions of the state, in reality, this is not true. One recent Health Affairs study shows that 42% of patient visits to nurse practitioners and physician assistants in office-based settings were to the offices of specialists not to primary care practices.

Again, the purpose in my reaching out to you today is to reemphasize the perspective of all of organized medicine which was shared by letter dated October 20, 2011. We need to establish "a structure whereby scope of practice issues may be examined by clinical professionals including primary care physicians, physician specialists and other health care professionals who will consider the clinical effectiveness and cost efficiency of the proposed scope of practice strategy, and its impact on integration of care."

Thank you for considering the views of New York State's physician community on these vitally important issues.

Sincerely,



Robert Hughes, MD  
President-Elect  
Medical Society of the State of New York