AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

TO: Members of the West Virginia House Committee on Health and Human Resources

FROM: American Osteopathic Association

DATE: January 27, 2026

SUBJECT: OPPOSITION to WV H.B. 4715

The American Osteopathic Association (AOA) writes today to express our concerns regarding WV H.B. 4715. This bill would greatly expand the scope of practice for both physician assistants (PAs) and certified nurse practitioners (CNPs) – which we will collectively refer to as non-physician providers (NPPs) – by allowing them to practice independently, without physician supervision or collaboration. The AOA shares the concerns of the West Virginia Osteopathic Medical Association that authorizing the independent practice of medicine by NPPs, who do not complete similar comprehensive medical education, training and competency demonstration requirements to what physicians complete, **could place the health and safety of patients at risk. We are also concerned that the strategy proposed in this bill would actually increase the cost of healthcare in West Virginia long-term, rather than leading to beneficial cost-savings**.

As a medical professional association representing more than 207,000 osteopathic physicians (DOs) and osteopathic medical students (OMSs) nationwide– including over 2,000 DOs and nearly 1,000 OMSs in West Virginia – the AOA works to promote evidence-based policies and sound public health practices that advance the overall health and well-being of patients across the country.

The AOA supports the "team" approach to medical care. This is because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. While we value the contributions of all health care providers to the health care delivery system, we believe that the education and training received by NPPs lack the comprehensive and robust requirements needed to properly ensure the same level of patient safety and care quality that is achieved through the rigorous education, training, and testing mandates for physicians in the United States. The requirements physicians complete ensure that all patients are treated with the same high standard of care regardless of their location or ability to pay. They also uniquely prepare physicians to understand and recognize the subtle differences between many minor ailments (i.e. the common cold, indigestion) and serious ones (i.e. pneumonia, heart attack) that share similar symptoms, and to engage in safe prescribing practices.

The educational differences between physicians and NPPs not only impact patient care, but also translates into hard dollars. A 2022 study conducted within the Veterans Health Administration (VHA) emergency departments and revised last month found that nurse practitioners (NPs) used more resources (ie. ordered more radiology tests, engaged in more formal consults, etc.) and had higher preventable hospitalization rates, even though NPs were seeing healthier patients than their physician counterparts. **Overall, NPs increased the patient length of stay by 11% and increased the costs of emergency department care by 7%[1].**

[1] "The Productivity of Professions: Evidence from the Emergency Department," David C. Chan, Jr. and Yiqun Chen, National Bureau of Economic Research, Nov. 2022, Updated Dec. 2025.

Despite NPs being more likely to prescribe antibiotics (which carry health risks if incorrectly prescribed), NP patients had higher rates of subsequent emergency department visits with infections. Also, while NPs were less likely to prescribe opioids to patients, their patients still had similar downstream opioid use disorder rates. In general, the study found that **allocating 25% of emergency department patients to NPs (as compared to allocating no patients) resulted in increased non-wage spending by $197 million per year[2]** – a figure close to the $199.5 million awarded to West Virginia by CMS for the Rural Health Transformation Program for FY 2026[3]**.** When the wage discrepancy between NPs and physicians was accounted for, **it was found that NPs still increased the VHA's spending by $129 million per year[4].**

Similarly, another 2022 study in Hattiesburg, Mississippi, found that care provided by non-physicians (both PAs and NPs) resulted in higher costs. Patients seeing a non-physician for primary care were 1.8% more likely to visit the emergency department than those with physicians providing primary care. (Again, this was despite the fact that the patients for non-physicians were younger and healthier.) Non-physicians were also 7 - 8% more likely to refer their patients, likely because their relatively limited training compared to physicians did not enable them to appropriately distinguish between cases requiring referral and those that did not.

Altogether, care from non-physicians resulted in higher costs: Medicare patients with a non-physician providing primary care cost **$43 per member per month more** than those Medicare patients with a primary care physicians, translating to an **additional $10.3 million per year in spending**. Even without the additional spending, however, the study showed that physicians generally outperformed non-physicians: physicians received higher patient satisfaction scores and performed better on 9 out of 10 quality metrics[5].

Despite driving up the costs of healthcare, NPPs often return to the legislature seeking pay parity with physicians once independent practice is obtained, as other states have experienced. This further exacerbates cost issues.

Finally, it should be noted that expanding scope of practice doesn't necessarily translate to more available primary care practitioners in rural areas. Heat-mapping in states with independent practice for PAs and NPs showed that NPPs continued to practice in the same areas as physicians, rather than moving into the rural areas they often pledge to serve in scope campaigns[6]. They are also not staying in primary care – a growing number of PAs and NPs are switching into more lucrative specialty or subspecialty care[7]. Even in states like Florida, which authorized independent practice for NPs in 2020 *only* in primary care, more than half of the NP respondents to a recent survey indicated that they were practicing in specialty care, undermining arguments that expanding scope will help address primary care workforce shortages[8].

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[2] "The Productivity of Professions: Evidence from the Emergency Department," David C. Chan, Jr. and Yiqun Chen, National Bureau of Economic Research, Nov. 2022, Updated Dec. 2025.
[3] *See* https://www.cms.gov/newsroom/press-releases/cms-announces-50-billion-awards-strengthen-rural-health-all-50-states
[4] "The Productivity of Professions: Evidence from the Emergency Department," David C. Chan, Jr. and Yiqun Chen, National Bureau of Economic Research, Nov. 2022, Updated Dec. 2025.
[5] "Targeting Value-Based Care with Physician-Led Care Teams," Bryan N. Batson, MD, Samuel N. Crosby, MD, and John Fitzpatrick, MD, Journal of the Mississippi State Medical Association, Jan. 2022
[6] *See* https://www.amascopeofpractice.org/sites/scope_of_practice/files/2025-11/AMA-Issue-Brief-Access-to-Care-2021.pdf
[7] *See* https://kffhealthnews.org/news/article/nurse-practitioners-trend-primary-care-specialties/
[8] *See* https://pubmed.ncbi.nlm.nih.gov/41473973/

For these reasons, we urge you to <u>vote NO on H.B. 4715</u>. The AOA stands ready to assist you in finding safe, proven alternatives to scope expansion, such as improving access to telemedicine and increasing medical student rotations and residency slots in high-need specialties and areas. Should you need any additional information, please contact Raine Richards, JD, Vice President of State and International Affairs at rrichards@osteopathic.org.

Sincerely,

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