Office of Policy Planning
Bureau of Competition
Bureau of Economics

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supervision of APRN practice raises competitive concerns, may impede access to care, and may frustrate the development of innovative and effective models of team-based health care.[5]

Expert bodies, including the Institute of Medicine ("IOM"),[6] have determined that APRNs are "safe and effective as independent providers of many health care services within the scope of their training, licensure, certification and current practice."[7] FTC staff have recommended, therefore, that policy makers carefully examine purported safety justifications for restrictions on APRN practice in light of the pertinent evidence, e

II. The Proposed Rule

The Proposed Rule would permit the VA to grant “full practice authority” to the four main categories of APRNs—Certified Nurse Practitioners (“CNPs”), Clinical Nurse Specialists (“CNSs”), Certified Nurse Midwives (“CNMs”), and Certified Registered Nurse Anesthetists (“CRNAs”) —provided certain background conditions are met.[15] Those background conditions include, among others, verification of an APRN’s credentials, including licensure under the laws of at least one state, and determination that the APRN has demonstrated the knowledge and skills necessary to providing the health care services that the VA requires.[16] “Full practice authority” is defined as the authority to provide services required by the VA, including services enumerated in the proposed rule, “without the clinical oversight of a physician, regardless of State or local law restrictions, when that APRN is working within the scope of their [sic] VA employment.”[17] As the Department notes, CNPs—the main category of primary care APRNs—already had such full practice authority under the laws of 21 states, plus the District of Columbia, as of March 7, 2016.[18] West Virginia also provided a path to independent APRN practice when it amended its nurse licensing statute on March 29, 2016.[19]

The Proposed Rule requires that VA-employed APRNs continue to meet established, national standards for APRN education, training, licensure, and certification.[20] The scope of practice of VA-employed APRNs would also be subject to any additional limits or conditions the VA itself might impose. Hence, as we read the Proposed Rule, the Department is not seeking to expand the scope or range of health care services that APRNs may provide or the indications that APRNs may treat. Rather, the Department appears to propose standardizing its APRN qualifications and practice guidelines and streamlining its ability to deploy its health care providers across state lines.[21]

III. L

robust utilization of APRNs could provide. The Policy Paper analyzes three basic issues of particular relevance to the Proposed Rule.

First, regulatory constraints on APRN practice limit the ability of APRNs to expand access to primary care services and to ameliorate both current and projected health care workforce shortages. The United States faces a substantial and growing shortage of physicians, especially in primary care.[24] As a result, many Americans may face limited access to basic health care services, particularly in poor or rural areas.[25] Due to physician shortages, there are approximately 6,100 primary care health professional shortage areas ("HPSAs") across the United States.[26]

The delivery of care in rural areas, and access to care for rural veterans who are VHA patients, may present particular challenges to the VA. As the Department itself notes in its 2015 report on rural health,

> [t]he disparity between health services available in urban hubs versus rural areas is impossible to ignore. For some, the gap is physical: long travel distances with limited public transit options mean more missed appointments. For others, unseen barriers block access to quality health care: too few specialists and uncertainty about enrollment eligibility keeps Veterans from services. Yet others struggle with social well-i3 Tc 0 Tw ot6 socia

of the barriers to rural health care access that are a byproduct of state-by-state regulatory variation.

Second, legal or regulatory hurdles to APRN practice may raise the costs of APRN services, thereby reducing supply and further diminishing access to basic primary care. APRNs tend to provide care at lower cost than physicians.[34] Mandatory supervision and "collaborative practice" requirements may, however, increase the cost of those services.[35] In contrast, when these types of supervisory requirements are relaxed, the supply of professionals willing to offer APRN services at any given price is likely to increase. In underserved areas and for underserved populations, the benefits of expanding supply are clear: consumers—and VHA patients in particular—may gain access to services that otherwise would be unavailable.[36] Even in well-served areas, a supply expansion tends to lower prices and drive down health care costs.[37] Hence, the VA may be better able to meet the needs of patients in underserved areas, and to serve all of its patients more effectively and efficiently.

Third, rigid supervision (and collaborative agreement) requirements may impede, rather than foster, development of effective models of health care delivery—including team-based care[38]—both within and outside the VHA system. In the private sector, health care providers that employ or contract with APRNs typically develop and implement their own practice protocols, hierarchies of supervision, and models of team-based care to promote quality of care, satisfy their business objectives, and comply with regulations. Collaboration between APRNs and physicians is common in all states, including those that permit APRNs to practice independently.[39] Most APRNs work for institutional providers or physician practices with established channels of collaboration and supervision, and even "independently" practicing APRNs typically consult physicians and refer patients as appropriate.[40]

The impact of unnecessary APRN regulations raises heightened concern in light of evidence that independent APRN practice might offer substantial clinical benefits to patients and, therefore, to health care providers, including institutional providers like the VHA. As noted above, the competition issues analyzed in the FTC staff Policy Paper reinforce health policy findings and recommendations of expert bodies such as the IOM. For example, a 2011 IOM report on the future of nursing ("IOM Future of Nursing Report") identifies a key role for APRNs in improving health care delivery, while expressing concern about undue restrictions on their prescription authority and scope of practice.[46] Based on a rigorous examination of APRN practice issues, the IOM found that "[r]estrictions on scope of practice . . . have undermined [nurses'] ability to provide and improve both general and advanced care."[47] Similarly, in 2012, the National Governors Association ("NGA") reported on APRNs' potential to address increased demand for primary care services, particularly in historically underserved areas.[48] The NGA report noted the high quality of primary care services provided by APRNs, who "may be able to mitigate projected shortages of primary care services."[49] A recent report by the Congress-established Commission on Care[50] notes, in particular, that, "policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care."[51] One of the Commission's central recommendations to improve clinical operations is that the Department "[d]evelop policy to allow full practice authority for APRNs."[52]

b. Restrictions Placed on Specialist APRNs Raise Similar Concerns

The VA has highlighted two categories of specialist APRNs in the Proposed Rule. First, the Proposed Rule would permit full practice authority for VA-employed CNMs.[53] Although the Department does not presently employ CNMs, it "would include the services of a CNM in this rulemaking in anticipation that VA would hire CNMs at a future date to improve access to health care for the increasing number of female veterans."[54] Second, the Proposed Rule would grant full practice authority to CRNAs.[55] In particular, given the diversity of stakeholder views on the topic, the Department has asked for comments on the question of full practice authority for CRNAs.[56]

Supervision requirements for CNMs and CRNAs raise competition concerns similar to those raised by the imposition of supervision requirements on primary care APRNs or CNPs.[57] FTC staff recognize that certain licensure requirements and scope-of-practice restrictions can serve to protect patients.[58] This is true for all APRNs and, indeed, for all health care professionals. In particular, special practice requirements or other restrictions may be recommended for indications or treatments associated with heightened patient risks.[59] We note, however, the IOM's concern that excessive restrictions may impede access to specialized care that CNMs and CRNAs are qualified to provide, based on their training and experience.[60] We also note the IOM's observation that "most states continue to restrict the practice of APRNs beyond what is warranted by either their education or their training," which "support broader practice by all types of APRNs."[61] Because particular regulatory restrictions on CNMs and CRNAs may dampen competition in ways that harm patients, institutional health care providers, and payors—without offering countervailing health and safety benefits—we have recommended that policy makers apply the same competition-oriented framework and considerations to all APRN policies, including those regarding specialist APRNs.[62]

Importantly, access problems are not unique to primary care. As the IOM points out, "[a]ccess to competent care is denied to patients, especially those located in rural, frontier, or other underserved areas, in the absence of a willing and available 'supervising' physician."[63] Yet specialist physicians such as obstetricians/gynecologists ("OB/GYNs") and anesthesiologists—and not just primary care doctors—may be in short supply,[64] particularly in rural areas.[65] A recent report on rural health policy notes that physician supply generally decreases as areas become more rural, and that this is particularly true for certain types of specialists.[66] For example, it has been observed that the supply of OB/GYNs decreases steadily as practice locales become more rural.[67] Correspondingly, many CRNAs provide basic anesthesia services in rural counties where there are no anesthesiologists.[68]

FTC staff urge the VA to consider whether

safe APRN practice, we believe those benefits could spill over into the private health care market as well. Accordingly, we encourage the VA to continue its efforts, as embodied in the Proposed Rule, to improve access to care for VHA patients, and to provide that care effectively and efficiently. Removing unnecessary and burdensome requirements on APRNs, consistent with patient health and safety, may help the VA achieve these important goals.

Respectfully submitted,

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Enclosure

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[1] This letter expresses the views of staff in the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize us to submit these comments.

[2] Advanced Practice Registered Nurses, 81 Fed. Reg. 33,155 (proposed May 25, 2016) (to be codified at 38 C.F.R. part 17).

[3] *Id.* at 33,155.

[4] FED. TRADE COMM'N STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [hereinafter FTC STAFF POLICY PAPER]. As noted in the FTC STAFF POLICY PAPER, "a state may impose certain 'collaborative practice' requirements on APRNs, requiring that an APRN enter into a written agreement with a physician to define the parameters of the APRN's permitted practice. This can be viewed as a *de facto* supervision requirement, to the extent that the APRN cannot practice without securing the approval of an individual physician, whereas the terms of physician practice are in no way dependent on APRN input." *Id.* at 11.

[5] *Id.* at 37.

[6] The IOM—established in 1970 as the health arm of the National Academy of Sciences—provides expert advice to policy makers and the public.

[7] FTC STAFF POLICY PAPER, *supra* note 4, at 2 n.6 and accompanying text (*citing* INST. OF MED., NAT'L ACAD. OF SCIENCES, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 98–99 (2011) [hereinafter IOM FUTURE OF NURSING REPORT]).

[8] Federal Trade Commission Act, 15 U.S.C. § 45.

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CARE'S MOST PRESSING CHALLENGES (2012), http://www.rwjf.org/content/dam/files/rwjf-web-files/Resources/2/cnf20120810.pdf.

[41] FTC STAFF POLICY PAPER, *supra* note 4, at 31 (citing Pamela Mitchell et al., *supra* note 39).

[42] Staff note, for example, the VA's focus on team-based care under its Patient Aligned Care Team, or PACT, program. *Team Based Care–PACT*, U.S. DEP'T VETERANS AFFAIRS, http://www.va.gov/HEALTH/services/primarycare/pact/team.asp.

[43] FTC STAFF POLICY PAPER, *supra* note 4, at 32.

[44] *Where do I get the care I need?*, U.S. DEP'T VETERANS AFFAIRS, http://www.va.gov/health/FindCare.asp.

[45] 81 Fed. Reg. at 33,156.

[46] *See generally* IOM FUTURE OF NURSING REPORT, *supra*

INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND 70–72, exs. 51–52 (2008), http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf [hereinafter HRSA PHYSICIAN WORKFORCE REPORT] (HRSA's most recent workforce report on physician supply and demand, projecting increased shortages of both primary care physicians and specialists).

[65] *See* ASS'N OF AM. MED. COLLS., *supra* note 64 (noting impact of physician shortfalls to be "most severe" in rural and other underserved areas); see also HRSA PHYSICIAN WORKFORCE REPORT, *supra* note 64, at 8, n. 4 (HRSA's supply model was designed primarily as a national model and thus did not track geographic differences, but HRSA nonetheless noted that "[t]he physician workforce is . . . unevenly distributed throughout the Nation, with pockets of severe shortages (primarily in poor, rural and inner-city areas)."); IOM FUTURE OF NURSING REPORT, *supra* note 7, at 106–07; MICHAEL MEIT ET AL., RURAL HEALTH REFORM POLICY RESEARCH CENTER, THE 2014 UPDATE OF THE RURAL–URBAN CHARTBOOK 56 (2014) [hereinafter MEIT ET AL.].

[66] MEIT ET AL., *supra* note 65, at 4. Overall, according to the National Rural Health Association, there are more than three times as many specialists per 100,000 people practicing in urban areas as in rural areas. *What's Different About Rural Health Care*, NAT'L RURAL HEALTH ASS'N, http://www.ruralhealthweb.org/go/left/about-rural-health (last visited Jan. 11, 2016).

[67] MEIT ET AL., *supra* note 65, at 56 (finding 16 OB/GYNs per 100,000 persons in central counties of large metro areas but only 3 OB/GYNs per 100,000 persons in most rural counties).

[68] *See, e.g.*, FTC Staff Letter to the Hon. Jeanne Kirkton, Missouri House of Representatives, Concerning Missouri House Bill 1399 and the Regulation of Certified Registered Nurse Anesthetists, at 3 (March 2012), http://www.ftc.gov/os/2012/03/120327kirktonmissourileter.pdf ("Staff notes that CRNA practices disproportionately serve rural patients, and the Missouri Association of Nurse Anesthetists has testified that CRNAs are the only licensed providers of anesthesia services in 31 Missouri counties."); FTC Staff Letter to the Hon. Gary Odom, Representative, Tennessee House of Representatives, Concerning Tennessee House Bill 1896 and the Regulation of Providers of Interventional Pain Management Services, at 4 (Sept. 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-gary-odom-tennessee-house-representatives-concerning-tennessee-house-bill.b.1896-and-regulation-providers-interventional-pain-management-services/v11001tennesseebill.pdf (CRNAs only licensed providers of anesthesia services in 39 Tennessee counties); *cf.*

[74] Am. Coll. Nurse Midwives & Am. Coll. Obstetricians and Gynecologists, Joint Statement of Practice Relations Between Obstetricians-Gynecologists and Nurse Midwives/Certified Midwives, Feb. 2011 (Reaffirmed by ACOG Exec. Bd. July 2014).

[75] Id.