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Office of Policy Planning
Bureau of Competition
Bureau of Economics

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Director, Regulations Management (02REG)
Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1068
Washington, DC 20420

Re: RIN 2900–AP44-Advanced Practice Registered Nurses

The staffs of the Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition (“FTC staff”) ¹ appreciate the opportunity to respond to your request for comments on the Department of Veterans Affairs’ (the “Department” or the “VA”) proposed rule, “Advanced Practice Registered Nurses” (“Proposed Rule”).² For reasons explained below, FTC staff support the Department’s initiative to maximize its staff capabilities. Our prior examination of the impact of nursing regulations on health care competition reinforce the VA’s view that the Proposed Rule would:

- increase the Veterans Health Administration’s (“VHA”) ability to provide timely, efficient, and effective primary care services, among others; and
- increase veteran access to needed health care, particularly in medically underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments.³

These changes in VA policy may also benefit health care consumers in private markets.

FTC staff’s interest in nursing regulation derives from our expertise in health care competition issues. The enclosed 2014 FTC staff policy paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses* (“Policy Paper”), analyzes the competitive implications of various Advanced Practice Registered Nurse (“APRN”) regulations, including mandatory physician-supervision or “collaborative practice” agreements.⁴ As explained in the Policy Paper, FTC staff recognize the critical importance of patient health and safety, and we defer to federal and state legislators to determine the best balance of policy priorities and to define the appropriate scope of practice for APRNs and other health care professionals. But even well-intentioned laws and regulations may include unnecessary or overbroad restrictions that limit competition. Undue regulatory restrictions on APRN practice can harm patients, institutional health care providers such as the VHA, and both public and private third-party payors. The Policy Paper observes, in particular, that state-mandated

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, evaluate whether such justifications are well founded, and consider whether less restrictive alternatives would protect patients without imposing undue burdens on competition and undue limits on patients’ access to basic health care services.

FTC staff urge the VA to apply a similar analytical framework. Granting full practice authority to VA-employed APRNs would benefit both the VA and the patients it serves, consistent with the goals expressed in the Proposed Rule. APRNs should be able, for example, to evaluate VA patients, order diagnostic tests for them, and manage their treatments without physician involvement or approval as long as they do so within the limits of their education and training. Furthermore, the VA’s actions and leadership on this issue may send an important signal (and generate useful data) regarding the likely benefits of full practice authority for APRNs. This, in turn, could influence broader policy considerations, as well as provider market entry outside the VA system, both of which may help to bring the benefits of increased health care competition to an even larger number of U.S. citizens and permanent residents.

I. INTEREST AND EXPERIENCE OF THE FTC

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁸ Competition is at the core of America’s economy,⁹ and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and greater innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,¹⁰ research,¹¹ and advocacy.¹² In addition to the attached Policy Paper, FTC staff have submitted written comments analyzing the likely competitive effects of proposed APRN regulations in various states, and observing that removing excessive supervision requirements can achieve significant consumer benefits.¹³

Competition advocacy by the FTC and its staff typically focuses on the impact of regulation on competition in the private sector and, ultimately, on consumers.¹⁴ Therefore, the FTC has an interest in the Proposed Rule to the extent that the VA’s actions may encourage entry into health care service provider markets, broaden the availability of health care services outside the VHA system, as well as within it, and yield information about new models of health care delivery. We believe our experience with competition and professional regulations in the private sector may inform and support the VA’s endeavor.

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. LIKELY IMPACT OF THE PROPOSED RULE

a. Excessive Restrictions on Advanced Practice Nursing Raise Competition Concerns That May Impact Access, Cost, and Quality of Care

FTC staff recognize that certain professional licensure requirements and scope-of-practice restrictions may protect patients.²² Consistent with patient safety, however, we have urged regulators and legislators to consider that independent practice by APRNs may facilitate greater competition, which also may benefit patients. If APRNs are better able to practice to the full extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, health care consumers—including VA patients—are likely to benefit from improved access to health care, lower costs, and additional innovation.

Section III of the FTC staff Policy Paper discusses in detail the potential competitive harms from overly restrictive APRN supervision requirements, including the types of mandatory collaborative practice agreements that roughly half the states now require.²³ The Policy Paper analyzes these competitive harms as potential consequences of market-wide regulations, and the potential benefits of policy reform as those likely to follow the repeal or retrenchment of such regulatory constraints. Lifting such constraints for a large health care system, such as the VA, would at least permit that system’s health care consumers to recognize the benefits that more

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-being in rural communities, where housing, educational and employment options may be limited.²⁷

Expanded APRN practice is widely regarded as a key strategy to alleviate such provider shortages, especially in medically underserved areas and for medically underserved populations.²⁸ Nationally, APRNs already “make up a greater share of the primary care workforce in less densely populated areas, less urban areas, and lower income areas, as well as in HPSAs.”²⁹

FTC staff note, in particular, the VA’s extensive use of telehealth programs to provide care for rural veterans.³⁰ Given those programs, the Proposed Rule may give the VA more staffing flexibility in patient monitoring and case management for VHA patients who do not have easy in-person access to VA medical centers.³¹ State-based licensing restrictions may erect barriers to the flow of health care information to and from qualified practitioners across state lines. At present, those barriers may vary according to the particulars of each state’s licensure, scope-of-practice, health information, and telehealth regulations, for reasons unrelated to health and safety standards.³² For example, due to variation in state regulations, an APRN’s monitoring of chronic care patients by telephone or other electronic means might be permissible or impermissible according to the channel of communication, the location of the patient, the location of the APRN, or the physical distance between the APRN and a particular, contractually established, supervising physician. As observed in a 2004 joint report by the FTC and the Department of Justice (“DOJ”), “the practice of telemedicine has ... crystallized tensions between the states’ role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state . . . [practitioners] from out-of-state competition.”³³ By permitting VA APRNs to deliver additional care where VHA patients are located, the Proposed Rule may reduce some

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 care³⁸—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

Importantly, these new models of collaboration represent a fertile area of innovation in health care delivery. Proponents of team-based care have recognized the virtues of such innovation, given the myriad approaches to team-based care that may succeed in different practice settings.⁴¹ Innovation in team-based care should be just as important to public health care providers like the VHA⁴² as it is to providers in the private sector. The Proposed Rule would expand the VA’s options to innovate and experiment with models of team-based care, as well as other forms of collaboration and oversight.

Rigid collaborative practice requirements therefore “can arbitrarily constrain this type of innovation, as they can impose limits or costs on new and beneficial collaborative arrangements, limit a provider’s ability to accommodate staffing changes across central and satellite facilities or preclude some provider strategies altogether.”⁴³ This last point may have special significance to the VA, which has facilities and patient-care obligations that extend across the United States and comprise various practice settings.⁴⁴ FTC staff have reviewed reports from expert health agencies as well as the published academic literature, and are unaware of evidence that practice agreement requirements imposed by state statutes are needed to achieve the benefits of team-based health care. The VA’s proposed exercise of federal preemption to override state nursing licensure laws that conflict with the grant of full practice authority to VA APRNs, acting within the scope of their VA employment, may therefore facilitate the Department’s implementation of innovative strategies across different facilities and practice settings around the country.⁴⁵

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 Care⁵⁰ 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 CRNAs and CNMs can help alleviate the access problems associated with specialist physician shortages, in a manner consistent with patient health and safety. For example, the IOM Future of Nursing Report observes that CRNAs administer more than 65 percent of all anesthetics to U.S. patients and that they “[a]dminister anesthesia and provide related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as pain management.”⁶⁹ Based on the safety literature, the IOM states: “evidence shows that CRNAs provide high-quality care . . . [while] there is no evidence of patient harm from their practice.”⁷⁰ Similarly, the U.S. Department of Health and Human Services has, on multiple occasions relating to Medicare and Medicaid rules for the provision of hospital anesthesia services, reviewed the available literature on the quality of anesthesia services, and has not found risks that would warrant further restrictions on CRNA practice.⁷¹

Similar evidence supports expanded scope of practice for CNMs, which we urge the VA to consider. The IOM has also observed that CNMs, working within their scope of practice, provide high-quality care—noting, for example, that “[t]wo systematic reviews have found that women given midwifery care are more likely to have shorter labors, spontaneous vaginal births without hospitalization, less perineal trauma, higher breastfeeding rates, and greater satisfaction with their births.”⁷² The American Congress of Obstetricians and Gynecologists “supports the full scope of practice for CNMs.”⁷³ Its companion organization, the American College of Obstetricians and Gynecologists recognizes that CNMs are “independent providers” who, like OB/GYNs, are “experts in their respective fields of practice.”⁷⁴ Instead of recommending mandatory supervision or formal “collaborative practice” agreements, they suggest that OB/GYNs and CNMs “may collaborate with each other based on the needs of their patients”⁷⁵—an approach that FTC staff believe would be consistent with the procompetitive principles outlined above.

IV. CONCLUSION

FTC staff support the VA’s efforts to grant full practice authority to APRNs, by removing the remaining state-law-based supervision restrictions on APRN scope of practice for APRNs within the VHA system. We strongly believe that full APRN practice authority can benefit the VA’s patients and the institution itself, by improving access to care, containing costs, and expanding innovation in health care delivery. To the extent that the VA’s actions would spur additional competition among health care providers and generate additional data in support of

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

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.

⁹ *Standard Oil Co. v. Fed. Trade Comm’n*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

¹⁰ *See Competition in the Health Care Marketplace*, FED. TRADE COMM’N, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>.

¹¹ *See* FED. TRADE COMM’N & U.S. DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf> [hereinafter FTC & DOJ, IMPROVING HEALTH CARE].

¹² FTC and staff advocacy may consist of letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Letter from FTC Staff to the Hon. Timothy G. Burns, Representative, La. House of Representatives (May 1, 2009), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-louisiana-house-bill-687-practice/v090009louisianadentistry.pdf (regarding proposed restrictions on mobile dentistry); Joint Statement from the FTC and DOJ to the Ill. Task Force on Health Planning Reform (Sept. 15, 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-and-department-justice-written-testimony-illinois-task-force-health-planning-reform-concerning/v080018illconlaws.pdf (concerning Illinois certificate of need laws); Brief of Amicus Curiae Federal Trade Commission in Support of Appellants and Urging Reversal, *Ciprofloxacin Hydrochloride Antitrust Litig.*, 544 F.3d 1323 (Fed. Cir. 2008) (No. 2008-1097), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-amicus-curiae-brief-re-ciprofloxacin-hydrochloride-antitrust-litigation-concerning-drug-patent/080129cipro.pdf; FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 11.

¹³ *See, e.g.*, FTC Staff Comment to the Hon. Mike Pushkin, Delegate, W.V. House of Delegates (Mar. 9, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf; Letter from FTC Staff to the Hon. Jenny A. Horne, Representative, S.C. House of Representatives, regarding House Bill 3508 and 3078 on Advanced Practice Registered Nurse Regulations (Nov. 2, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-south-carolina-representative-jenny.horne-regarding-house-bill-3508-3078-advanced-practice-registered-nurse-regulations/151103scaprn.pdf; Letter from FTC Staff to the Hon. Jeanne Kirkton, Representative, Mo. House of Representatives (Apr. 21, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-representative-jeanne-kirkton-missouri-house-representatives-regarding-competitive/150422missourihouse.pdf (regarding collaborative practice arrangements between physicians and APRNs); Letter from FTC Staff to the Hon. Kay Khan, Representative, Mass. House of Representatives (Jan. 17, 2014), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-massachusetts-house-representatives-regarding-house-bill-6-h.2009-concerning-supervisory-requirements-nurse-practitioners-nurse-anesthetists/140123massachusettsnursesletter.pdf (regarding supervisory requirements for nurse practitioners and nurse anesthetists); Letter from FTC Staff to Theresa W. Conroy, Representative, Conn. House of Representatives (Mar. 19, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-theresa-w.conroy-connecticut-house-representatives-concerning-likely-competitive-impact-connecticut-house-bill/130319aprnconroy.pdf (APRNs); Prepared Statement from FTC Staff to Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature (Sept. 10–12, 2012), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-testimony-subcommittee-wv-legislature-laws-governing-scope-practice-advanced-practice/120907wvatestimony.pdf (APRNs); Letter from FTC Staff to Thomas P. Willmott & Patrick C. Williams, Representatives, La. House of Representatives (Apr. 20, 2012), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-likely-competitive-impact-louisiana-house-bill-951/120425louisianastaffcomment.pdf (APRNs in medically underserved areas); Brief of the Federal Trade Commission as Amicus Curiae on Appeal from United

States District Court, *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605 (6th Cir. 1990), *appealing* 689 F. Supp. 799 (M.D. Tenn. 1988); FTC Staff Comment Before the Council of the District of Columbia Concerning Proposed Bill 6-317 to Create Specific Licensing Requirements for Expanded Role Nurses (Nov. 1985) (nurse midwives, nurse anesthetists, and nurse practitioners).

¹⁴ *License to Compete: Occupational Licensing and the State Action Doctrine: Hearing Before the S. Comm. on the Judiciary, Subcomm. On Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. 1–2 (2016), <https://www.ftc.gov/public-statements/2016/02/prepared-statement-federal-trade-commission-license-competitive-occupational>; *Barriers to Entrepreneurship: Examining the Anti-Trust Implications of Occupational Licensing: Hearing Before the H. Comm. on Small Bus.*, 113th Cong. 1–3 (2014) (statement of Fed. Trade Comm’n on Competition and the Potential Costs and Benefits of Professional Licensure), <https://www.ftc.gov/public-statements/2014/07/prepared-statement-federal-trade-commission-competition-potential-costs>.

¹⁵ 81 Fed. Reg. at 33156–58, 33,160 (to be codified at 38 C.F.R. § 17.415(c)).

¹⁶ 81 Fed. Reg. at 33156–57, 33160 (to be codified at 38 C.F.R. § 17.415(a) & (c)).

¹⁷ *Id.* (to be codified at § 17.415(b)).

¹⁸ 81 Fed. Reg. at 33,155. According to the Department, at the same time, CRNAs had full practice authority in 17 states. *Id.*

¹⁹ W.V. House Bill 4334, amending Section 30 of the W.V. Code, was approved by the Governor of West Virginia on March 29, 2016, http://www.legis.state.wv.us/Bill_Status/bills_history.cfm?INPUT=4334&year=2016&sessiontype=RS.

²⁰ *See* notes 16–17 *supra*.

²¹ By “standardize,” we do not suggest that the VA plans, or should plan, to implement any particular model of team-based care or to deploy all VA APRNs in the same way. Rather, the VA would be able to employ standard criteria for determining the best uses of its APRNs to meet the needs of its 8.67 million patients across its more than 1,700 diverse care sites. *Veterans Health Administration*, U.S. DEP’T OF VETERANS AFFAIRS, <http://www.va.gov/health/> (last visited June 30, 2016). Regulations, guidelines, and the ability to follow traveling patients would not have to vary according to arbitrary differences in state supervision requirements in the 28 states that now require some particular form of physician supervision or “collaborative practice.”

²² For example, licensure requirements or scope-of-practice restrictions may sometimes offer an efficient response to certain types of market failure arising in professional services markets. *See* CAROLYN COX & SUSAN FOSTER, FED. TRADE COMM’N, BUREAU OF ECONOMICS, *THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION* 5–6 (1990), <http://www.ftc.gov/ibc/consumerbehavior/docs/reports/CoxFoster90.pdf>.

²³ *See* notes 18–19 *supra*. Somewhat more than half of the states still require some form of physician supervision for APRNs, although the particulars of those requirements vary state-by-state. *Id.* Requirements also vary somewhat for different categories of APRNs. According to the National Council of State Boards of Nursing, under slightly different criteria than those for the VA’s “full practice authority,” 22 states and the District of Columbia permit “independent practice” by CRNAs, Nat’l Council State Bds. Nursing, CRNA Independent Practice Map, <https://www.ncsbn.org/5404.htm>, and 25 states and the District of Columbia permit “independent practice” by CNMs, Nat’l Council State Bds. Nursing, CRNA Independent Practice Map, <https://www.ncsbn.org/5405.htm> (last visited June 20, 2016).

²⁴ FTC STAFF POLICY PAPER, *supra* note 4, at 20.

²⁵ *Id.* at 21; IOM FUTURE OF NURSING REPORT, *supra* note 7, at 106–07 (“Expanding the scope of practice for NPs is particularly important for the rural and frontier areas of the country. Twenty-five percent of the U.S. population lives in these areas; however, only 10 percent of physicians practice in these areas (NRHA, 2010). People who live in rural areas are generally poorer and have higher morbidity and mortality rates than their counterparts in suburban and urban settings, and they are in need of a reliable source of primary care providers (NRHA, 2010).”).

²⁶ U.S. DEP’T HEALTH & HUMAN SERVS., HEALTH RESOURCE & SERVS. ADMIN., Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, <http://www.hrsa.gov/shortage/> (last visited June 16, 2016).

²⁷ U.S. DEP'T VETERANS AFFAIRS, OFFICE OF RURAL HEALTH, THRIVE 2015: OFFICE OF RURAL HEALTH ANNUAL REPORT 3 (2015) [hereinafter OFFICE OF RURAL HEALTH ANNUAL REPORT].

²⁸ See, e.g., IOM FUTURE OF NURSING REPORT, *supra* note 7, at 27–28; NAT'L GOVERNORS ASS'N, NGA PAPER: THE ROLE OF NURSE PRACTITIONERS IN MEETING INCREASING DEMAND FOR PRIMARY CARE 11 (2012), <http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf> [hereinafter NAT'L GOVERNORS ASS'N, NGA PAPER]. We do not mean to suggest that reforming APRN scope-of-practice restrictions is a panacea for primary care access problems. Rather, reducing undue restrictions on APRN scope of practice can be one significant way to help ameliorate existing and projected access problems. [undue hyperlink on highlighted part]

²⁹ FTC STAFF POLICY PAPER, *supra* note 4, at 25.

³⁰ *VA Reaching Out to Rural Veterans with Telehealth*, U.S. DEP'T VETERANS AFFAIRS <http://www.va.gov/health/NewsFeatures/20110816a.asp> (last visited June 21, 2016); OFFICE OF RURAL HEALTH ANNUAL REPORT, *supra* note 27, at 3, 10.

³¹ Information on the VA's telehealth resources and programs can be found at <http://www.telehealth.va.gov/>.

³² See, e.g., INST. OF MED., NAT'L ACAD. OF SCIENCES, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 20–21 (2012); Daniel J. Gilman, *Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practicing Globally While Regulating Locally*, 14 J. HEALTH CARE L. & POL'Y 87, 89 (2011) (“[T]elemedicine promises in various ways to reduce the costs and extend the reach of many health care services, but the advantages of remote and networked expertise may be poorly accommodated by licensing schemes that were developed to regulate local medical practices - practices historically dominated by face-to-face encounters between a [practitioner] and her patient.”)

³³ FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 11, ch. 2, at 32.

³⁴ *Id.* at 28. For example, a study conducted for the Commonwealth of Massachusetts by the RAND Corporation suggests concrete savings that might be associated with expanded APRN (and PA) scope of practice, due to the lower costs and prices that tend to be associated with APRN-delivered services: “between 2010 and 2020, Massachusetts could save \$4.2 to \$8.4 billion through greater reliance on NPs and PAs in the delivery of primary care.” CHRISTINE E. EIBNER ET AL., RAND HEALTH REPORT SUBMITTED TO THE COMMONWEALTH OF MASSACHUSETTS, CONTROLLING HEALTH CARE SPENDING IN MASSACHUSETTS: AN ANALYSIS OF OPTIONS 103–04 (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.pdf (describing conditions for upper and lower bound estimates and projections) [hereinafter RAND HEALTH REPORT].

³⁵ FTC STAFF POLICY PAPER, *supra* note 4, at 27–31.

³⁶ “Expanded APRN practice is widely regarded as a key strategy to alleviate provider shortages, especially in primary care, in medically underserved areas, and for medically underserved populations.” FTC STAFF POLICY PAPER, *supra* note 4, at 20 (citing, e.g., IOM FUTURE OF NURSING REPORT, *supra* note 7, at 98–103, 157–61, annex 3-1 (2011); RAND HEALTH REPORT, *supra* note 34, at 99; NAT'L GOVERNORS ASS'N, NGA PAPER, *supra* note 28.

³⁷ The National Governors Association recognized the impact of this supply expansion in its primary care paper, *supra* note 28.

³⁸ FTC STAFF POLICY PAPER, *supra* note 4, at 34.

³⁹ Regarding diverse practice settings and collaboration, see IOM FUTURE OF NURSING REPORT, *supra* note 7, at 23, 58–59, 65–67, 72–76; see generally Pamela Mitchell et al., *Core Principles & Values of Effective Team-Based Health Care* (Institute of Medicine, Discussion Paper, 2012), <http://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf> (IOM-sponsored inquiry into collaborative or team-based care).

⁴⁰ A report by the Robert Wood Johnson Foundation describes several private and public models of innovative ways to use APRNs in team-based care. ROBERT WOOD JOHNSON FOUND., HOW NURSES ARE SOLVING SOME OF PRIMARY 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).

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- 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* note 7 (especially Summary, 1-15; 99–102).
- ⁴⁷ *Id.* at 4.
- ⁴⁸ NAT’L GOVERNORS ASS’N, NGA PAPER, *supra* note 28.
- ⁴⁹ *Id.* at 11.
- ⁵⁰ The Commission was established under the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).
- ⁵¹ COMMISSION ON CARE, FINAL REPORT OF THE COMMISSION ON CARE 5 (2016), https://commissiononcare.sites.usa.gov/files/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf.
- ⁵² *Id.* at 39.
- ⁵³ 81 Fed. Reg. at 33,156–57.
- ⁵⁴ *Id.*
- ⁵⁵ *Id.* (to be codified at § 17.415(d)(1)(ii)).
- ⁵⁶ *Id.*
- ⁵⁷ As noted above, there are four types of APRNs: nurse practitioners (“CNPs”); nurse midwives (“CNMs”); certified registered nurse anesthetists (“CRNAs”); and clinical nurse specialists (“CNSs”). *Id.* at 33,155, 33,160 (to be codified at § 17.415(a)); *see also* IOM FUTURE OF NURSING REPORT, *supra* note 7, at 23, 26 table 1-1 (types of APRN practice). All four types of APRN consist of nurse practitioners with graduate nursing degrees, in addition to undergraduate nursing education and practice experience. IOM FUTURE OF NURSING REPORT, *supra* note 7, at 23, 26.
- ⁵⁸ FTC STAFF POLICY PAPER, *supra* note 4, at text accompanying notes 51–55.
- ⁵⁹ *See, e.g.*, FTC Staff Comment to the Hon. Heather A. Steans, Illinois State Senate, Concerning Illinois Senate Bill 1662 and the Regulation of Certified Registered Nurse Anesthetists (CRNAs), at 2–3 (April 2013), <http://www.ftc.gov/os/2013/04/130424illinois-sb1662.pdf>.
- ⁶⁰ IOM FUTURE OF NURSING REPORT, *supra* note 7, at 96.
- ⁶¹ *Id.* at 98 (emphasis added).
- ⁶² *See, e.g.*, Letter from FTC Staff to Kay Khan, Representative, Mass. House of Representatives, *supra* note 13 (regarding supervisory requirements for both nurse practitioners and nurse anesthetists); Letter from FTC Staff to Heather A. Steans, Senator, Ill. State Senate, *supra* note 55 (concerning the regulation of CRNAs); Brief of the Federal Trade Commission as Amicus Curiae on Appeal from United States District Court, Nurse Midwifery Associates v. Hibbett, 918 F.2d 605 (6th Cir. 1990), *appealing* 689 F. Supp. 799 (M.D. Tenn. 1988).
- ⁶³ IOM FUTURE OF NURSING REPORT, *supra* note 7, at 450.
- ⁶⁴ ASS’N OF AM. MED. COLLS., PHYSICIAN SHORTAGES TO WORSEN WITHOUT INCREASES IN RESIDENCY TRAINING (n.d.), https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf; BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES & SERVS. ADMIN., THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND 70–72, exs. 51–52 (2008), <http://bhpr.hrsa.gov/healthworkforce/reports/physwffissues.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/2012/03/120327kirktonmissouriletter.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. Letter from FTC Staff to the Hon. Kay Khan, Representative, Mass. House of Representatives, *supra* note 13, at 5 (geographic shortages of anesthesiologists in rural Massachusetts counties).

⁶⁹ IOM FUTURE OF NURSING REPORT, *supra* note 7, at 26.

⁷⁰ *Id.* at 111 (“A study . . . found no increase in inpatient mortality or complications in states that opted out of the CMS requirement that an anesthesiologist or surgeon oversee the administration of anesthesia by a CRNA.”).

⁷¹ For example, in 2001, the Centers for Medicaid and Medicare Services concluded that anesthesia services generally were safe and, in particular, that there was “no need for Federal intervention in State professional practice laws governing [CRNA] practice. . . . [and] no reason to require a Federal rule . . . mandating that physicians supervise the practice of [state-licensed CRNAs].” Dep’t Health & Human Servs. (HHS), Health Care Financing Administration (HCFA), Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services, 42 C.F.R. §§ 416, 482 & 485, Final Rule, 66 Fed. Reg. 4674, 4675 (Jan. 18, 2001); cf. HHS Health Care Financing Administration (HCFA), Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services, 42 C.F.R. §§ 416, 482 & 485, Final Rule, 66 Fed. Reg. 56,762, 56,762–63 (Nov. 13, 2001) (repeating observations on safety literature, but noting potential utility of independent study of question whether safety or quality effects are associated with state regulations permitting independent CRNA practice).

⁷² IOM FUTURE OF NURSING REPORT, *supra* note 7, at 57 (citing Marie Hatem et al., *Midwife-led Versus Other Models of Care for Childbearing Women*, COCHRANE DATABASE OF SYSTEMATIC REV. (4):CD004667 (2008); Ellen D. Hodnett et al., *Continuous Support for Women During Childbirth*, COCHRANE DATABASE OF SYSTEMATIC REV. 7(3) (2007)).

⁷³ Am. Cong. of Obstetricians & Gynecologists Comments to the Fed. Trade Comm’n, Apr. 30, 2014.

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.*