



UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20580

Office of Policy Planning  
Bureau of Competition  
Bureau of Economics

January 09, 2020

The Honorable Thomas E. Brinkman, Jr.  
Ohio House of Representatives  
77 S. High St, 11th Floor  
Columbus, OH 43215

Dear Representative Brinkman:

The Federal Trade Commission (“FTC” or “Commission”) Office of Policy Planning appreciates the opportunity to respond to your request for comments on House Bill 177 (“H.B. 177” or “the Bill”), a proposal to expand the scope of practice of Advanced Practice Registered Nurses (“APRNs”) in Ohio.<sup>1</sup> In particular, you asked for our input on the Bill’s proposal to “end the mandatory written collaborative agreement requirement.”<sup>2</sup> For reasons explained below, we urge the Ohio legislature to adopt that proposal and rescind the collaborative agreement requirement.

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.<sup>3</sup> 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

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<sup>1</sup> Letter from the Hon. Thomas E. Brinkman, Jr. to Bilal Sayyed, Director, FTC Office of Policy Planning (Oct. 18, 2019).

<sup>2</sup> *Id.*

<sup>3</sup> 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.

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, 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.<sup>4</sup>

As noted in the Policy Paper, the competitive risks associated with undue APRN restrictions may be heightened in rural and other medically underserved areas.<sup>5</sup> For that reason, the legislature may wish to focus not just on average or aggregate benefits that the Bill may promote for Ohio as a whole, but on health care cost and access problems facing, for example, the many Ohio counties that have been designated Governor’s Certified Shortage Areas.<sup>6</sup>

Expert bodies, including the Institute of Medicine (“IOM”),<sup>7</sup> 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.”<sup>8</sup> 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 Ohio legislature to apply a similar analytical framework. Granting full practice authority to Ohio APRNs would benefit Ohio health care consumers--patients, first and foremost, and both public and private third-party payors. APRNs should be able, for example, to evaluate 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.

## 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.<sup>9</sup> Competition is at the core of

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<sup>4</sup> *Id.* at 37.

<sup>5</sup> *See, e.g., id.* at 21-25.

<sup>6</sup> According to the Ohio Department of Health, 39 entire Ohio counties, and significant parts of 5 more Ohio counties, have been designated Governor’s Certified Shortage Areas. Ohio Dep’t Health, Ohio Governor’s Certified Shortage Areas (Oct. 21, 2019), [https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/state-office-of-rural-health/resources/sorh\\_rhc\\_gov](https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/state-office-of-rural-health/resources/sorh_rhc_gov) (last checked Dec. 10, 2019).

<sup>7</sup> The IOM—established in 1970 as the health arm of the National Academy of Sciences—provides expert advice to policy makers and the public.

<sup>8</sup> FTC STAFF POLICY PAPER, *supra* note 3, 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]).

<sup>9</sup> Federal Trade Commission Act, 15 U.S.C. § 45.

America's economy,<sup>10</sup> and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and greater innovation. "[C]ompetition among employers [also] helps actual and potential employees through higher wages, better benefits, or other terms of employment."<sup>11</sup> 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,<sup>12</sup> research,<sup>13</sup> and advocacy.<sup>14</sup> 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.<sup>15</sup>

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<sup>10</sup> *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.").

<sup>11</sup> FED. TRADE COMM'N & U.S. DEPT'T OF JUSTICE, ANTITRUST GUIDANCE FOR HUMAN RESOURCE PROFESSIONALS 2 (2016), [https://www.ftc.gov/system/files/documents/public\\_statements/992623/ftc-doj\\_hr\\_guidance\\_final\\_10-20-16.pdf](https://www.ftc.gov/system/files/documents/public_statements/992623/ftc-doj_hr_guidance_final_10-20-16.pdf).

<sup>12</sup> See Fed. Trade Comm'n, Competition in the Health Care Marketplace, Cases, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>.

<sup>13</sup> 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].

<sup>14</sup> FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. See, e.g., Joint Statement of the Fed. Trade Comm'n and the Antitrust Div. of the U.S. Dep't Justice Regarding Certificate-of-Need (CON) Laws and Alaska Senate Bill 62, Which Would Repeal Alaska's CON Program (2017), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006\\_ftc-doj\\_comment\\_on\\_alaska\\_senate\\_bill\\_re\\_state\\_con\\_law.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf); FTC Staff Comment Before the Dep't of Health & Human Servs. Regarding the 21<sup>st</sup> Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-department-health-human-services-regarding-21st-century-cures-act-interoperability/v190002\\_hhs\\_onc\\_info\\_blocking\\_staff\\_comment\\_5-30-19.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-health-human-services-regarding-21st-century-cures-act-interoperability/v190002_hhs_onc_info_blocking_staff_comment_5-30-19.pdf); Brief for the United States and the *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>; Fed. Trade Comm'n as *Amici Curiae* Supporting Plaintiffs-Appellees, *Teladoc, Inc. v. Texas Medical Board*, (5<sup>th</sup> Cir. Dec. 9, 2016) (Case: 16-50017); Fed. Trade Comm'n, *The Strength of Competition in the Sale of Rx Contact Lenses: An FTC Study* (2005), (<https://www.ftc.gov/sites/default/files/documents/reports/strength-competition-sale-rx-contact-lenses-ftc-study/050214contactlensrpt.pdf>).

<sup>15</sup> See, e.g., FTC Staff Comment to the Hon. Kent Leonhardt, Senator, Senate of West Virginia, Concerning the Competitive Impact of WV Senate Bill 516 on the Regulation of Certain Advanced Practice Registered Nurses (Feb. 2016), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.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](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](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

## II. H.B. 177

The Bill, as noted in your letter, would strike the Ohio requirement that a written collaborative agreement is a general precondition of APRN practice for three of the four major categories of APRN: certified nurse practitioner (“CNP”), certified nurse specialist (“CNS”), and certified nurse-midwife (“CNM”).<sup>16</sup> For example, the Bill would maintain a CNP’s ability to “provide preventive and primary care services . . . consistent with the nurse’s education and certification, and in accordance with rules adopted by the board [of nursing],” but would eliminate the requirement that she or he do so under a mandatory collaborative agreement.<sup>17</sup> Similarly, the Bill would maintain a CNP’s ability to “prescribe drugs and therapeutic devices” in accordance with Ohio law, but would eliminate the additional requirement of a mandatory collaborative agreement.<sup>18</sup>

The Bill also would maintain the ability of a CNS or a CNM to provide and manage care “consistent with the nurse’s education and in accordance with rules adopted by the board,” and to prescribe drugs and therapeutic devices as provided under Ohio law, but would eliminate the requirement that she or he do so “in collaboration with one or more physicians or podiatrists.”<sup>19</sup> In addition, the Bill would provide for the reimbursement of APRNs without such mandatory collaboration,<sup>20</sup> and it would permit schools to depend on licensed APRNs to clear students for participation in school sports, without such mandatory, formalized collaboration.<sup>21</sup>

While proposing to remove the requirement of a formal collaboration arrangement, the Bill would not otherwise alter the substantive licensing requirements for Ohio APRNs, and the Bill would not alter the scope of practice of CNPs, CNSs, or CNMs, according to their education, training, or experience, and according to Ohio laws or regulations.

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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](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](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).

<sup>16</sup> See, e.g., OHIO REV. CODE ANN. § 4723.01(H-J) (definitions in occupational code regarding nurses). Although the supervision of certified registered nurse anesthetists raises analogous competition concerns, these are not addressed in the Bill and hence not discussed in these comments).

<sup>17</sup> Proposed OHIO REV. CODE ANN. § 4723.432; see also Proposed OHIO REV. CODE ANN. § 4723.481 (Rescinding the requirement that the prescriptive authority of a CNP, CNS, or CNM is limited by the prescriptive authority of a particular collaborating physician or podiatrist.)

<sup>18</sup> *Id.*

<sup>19</sup> Proposed OHIO REV. CODE ANN. § 4723.43(A) (regarding CNMs) and (D) (regarding CNSs).

<sup>20</sup> Proposed OHIO REV. CODE ANN. § 3923.301.

<sup>21</sup> Proposed OHIO REV. CODE ANN. § 3313.539.

### 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.<sup>22</sup> 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 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.<sup>23</sup> 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. 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.<sup>24</sup> As a result, many Americans may face limited access to basic health care services, particularly in poor or rural areas.<sup>25</sup> Due to physician shortages, there are approximately 6,900 primary care health professional shortage areas (“HPSAs”) across the

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<sup>22</sup> 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/ib/consumerbehavior/docs/reports/CoxFoster90.pdf>.

<sup>23</sup> See See FTC STAFF POLICY PAPER, *supra* note 3, at 18–38. 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).

<sup>24</sup> FTC STAFF POLICY PAPER, *supra* note 3, at 20.

<sup>25</sup> *Id.* at 21; IOM FUTURE OF NURSING REPORT, *supra* note 8, 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).”).

United States.<sup>26</sup> Ohio has many such areas.<sup>27</sup> For example, according to the Ohio Department of Health, 39 entire Ohio counties, and significant parts of five more Ohio counties, have been designated Governor’s Certified Shortage Areas.<sup>28</sup> Such areas must be both rural (located outside a U.S. Census Bureau urbanized area) and underserved; that is, they must be either federally designated health professional shortage areas or medically underserved areas or Ohio designated shortage areas.<sup>29</sup>

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.<sup>30</sup> 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.”<sup>31</sup>

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 do.<sup>32</sup> But collaborative practice requirements may add additional costs to those services. Both patients and third-party payors are harmed to the extent that higher costs are passed along as higher prices.<sup>33</sup> In contrast, when collaborative practice requirements are reduced, 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

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<sup>26</sup> U.S. Dep’t Health & Human Servs., Health Resource & Servs. Admin., HRSA Data Warehouse Fact Sheet Maps FY 2018 (indicating 6,890 primary care HPSAs), <https://data.hrsa.gov/maps/fact-sheet-maps/> (last visited Dec. 9, 2019).

<sup>27</sup> Health Resources & Servs. Admin., data.hrsa.gov, Find Shortage Areas, <https://data.hrsa.gov/tools/shortage-area> (searchable database for health professional shortage areas and medically underserved areas, by state or county).

<sup>28</sup> See note 6, *supra*.

<sup>29</sup> Ohio Dep’t Health, Governor’s Certified Shortage Areas for Rural Health Clinics (Oct. 17, 2019), <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/primary-care-office/governor-s-certified-shortage-areas-rural-health-clinics> (last checked Dec. 10, 2019).

<sup>30</sup> See, e.g., IOM FUTURE OF NURSING REPORT, *supra* note 8, 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]

<sup>31</sup> FTC STAFF POLICY PAPER, *supra* note 3, at 25.

<sup>32</sup> *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, 103-104 (2009), [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2009/RAND\\_TR733.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.pdf) (describing conditions for upper and lower bound estimates and projections).

<sup>33</sup> FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 27-28.

benefits of expanding supply are clear: consumers may gain access to services that otherwise would be unavailable.<sup>34</sup> Even in well-served areas, a supply expansion tends to lower prices and drive down health care costs.<sup>35</sup>

Third, “rigid supervision [and collaborative agreement] requirements may impede, rather than foster, development of effective models of team-based care.”<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup> Moreover, new models of collaboration are an important area of innovation in health care delivery. Proponents of team-based care have recognized the importance of this innovation, given the myriad approaches to team-based care that may succeed in different practice settings.<sup>39</sup> Rigid collaborative practice requirements “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.”<sup>40</sup> FTC staff have reviewed reports from expert health agencies as well as the published academic literature, but are unaware of evidence that statutory practice agreement requirements are needed to achieve the benefits of team-based health care.

The competitive impact of unnecessary APRN regulations is concerning in light of evidence that independent practice--including independent prescribing--by APRNs might offer

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<sup>34</sup> “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 PERSPECTIVES, *supra* note 3, at 20 (citing, e.g., IOM FUTURE OF NURSING REPORT, *supra* note 8, at 98-103, 157- 61 annex 3-1 (2011); CHRISTINE E. EIBNER ET AL., RAND HEALTH REPORT SUBMITTED TO THE COMMONWEALTH OF MASSACHUSETTS, CONTROLLING HEALTH CARE SPENDING IN MASSACHUSETTS: AN ANALYSIS OF OPTIONS 99 (2009), [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2009/RAND\\_TR733.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.pdf); NAT’L GOVERNORS ASS’N, NGA PAPER, *supra* note 30.

<sup>35</sup> The National Governors Association recognized the impact of this supply expansion in its NGA PRIMARY CARE PAPER, *supra* note 34.

<sup>36</sup> FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 34.

<sup>37</sup> Regarding diverse practice settings and collaboration, see IOM FUTURE OF NURSING REPORT, *supra* note 8, at 23, 58-59, 65-67, 72-76; *see generally* Pamela Mitchell et al., *Core Principles & Values of Effective Team-Based Health Care* (Discussion Paper, Institute of Medicine 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).

<sup>38</sup> 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>.

<sup>39</sup> *Id.* at 31 (citing Pamela Mitchell et al., *supra* note 37).

<sup>40</sup> FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 32.

substantial benefits to Ohio health care consumers. 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 identifies a key role for APRNs in improving health care delivery, while expressing concern about undue restrictions on APRN prescribing and practice.<sup>41</sup> 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.”<sup>42</sup> 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.<sup>43</sup> 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.”<sup>44</sup>

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.<sup>45</sup> The Bill would expand the ability of Ohio’s providers 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.”<sup>46</sup> 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 elimination of Ohio’s formal collaboration requirements may therefore facilitate the implementation of innovative strategies across different facilities and practice settings.

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. 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

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<sup>41</sup> See generally IOM FUTURE OF NURSING REPORT, *supra* note 8 (especially Summary, 1-15; 99 - 102).

<sup>42</sup> *Id.* at 4.

<sup>43</sup> National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (Dec. 20, 2012), <http://www.nga.org/cms/home/nga-center-for-best-practices/center-divisions/page-health-division/col2-content/list--health-left/list-health-highlight/content-reference-2@/the-role-of-nurse-practitioners.html> [hereinafter NGA, *Role of Nurse Practitioners*].

<sup>44</sup> *Id.* at 11.

<sup>45</sup> FTC STAFF POLICY PAPER, *supra* note 3, at 31 (citing Pamela Mitchell et al., *supra* note 37).

<sup>46</sup> FTC STAFF POLICY PAPER, *supra* note 3, at 32.



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.<sup>47</sup> 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.”<sup>48</sup> 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.<sup>49</sup> 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.”<sup>50</sup>

### **b. Restrictions Placed on Specialist APRNs Raise Similar Concerns**

The Bill would address restrictions on two categories of specialist APRNs, in addition to CNPs: as noted above, the Bill would remove formal collaboration agreement requirements for CNSs and CNMs.<sup>51</sup> Such requirements for CNSs and CNMs raise competition concerns similar to those raised by the imposition of supervision requirements on primary care APRNs or CNPs.<sup>52</sup> Here too, FTC staff recognize that certain licensure requirements and scope-of-practice restrictions can serve to protect patients.<sup>53</sup> 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.<sup>54</sup> We note, however, the IOM’s concern that excessive restrictions may impede access to specialized care that CNSs and CNMs are qualified to provide, based on their training and experience.<sup>55</sup> 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*.”<sup>56</sup> Because particular regulatory restrictions on CNSs and CNMs 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

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<sup>47</sup> See generally IOM FUTURE OF NURSING REPORT, *supra* note 8 (especially Summary, 1-15; 99–102).

<sup>48</sup> *Id.* at 4.

<sup>49</sup> NAT’L GOVERNORS ASS’N, NGA PAPER, *supra* note 28.

<sup>50</sup> *Id.* at 11.

<sup>51</sup> See notes 19 - 21, and accompanying text.

<sup>52</sup> 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 8, 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 8, at 23, 26.

<sup>53</sup> FTC STAFF POLICY PAPER, *supra* note 3, at text accompanying notes 51–55.

<sup>54</sup> 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>.

<sup>55</sup> IOM FUTURE OF NURSING REPORT, *supra* note 8, at 96.

<sup>56</sup> *Id.* at 98 (emphasis added).

makers apply the same competition-oriented framework and considerations to all APRN policies, including those regarding specialist APRNs.<sup>57</sup>

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.”<sup>58</sup> Yet specialist physicians such as obstetricians/gynecologists (“OB/GYNs”)—and not just primary care doctors—may be in short supply,<sup>59</sup> particularly in rural areas.<sup>60</sup> 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.<sup>61</sup> For example, it has been observed that the supply of OB/GYNs decreases steadily as practice locales become more rural.<sup>62</sup>

FTC staff urge you to consider whether CNSs 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 has observed that CNMs, working within their scope of practice, provide high-quality care—noting 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.”<sup>63</sup> The American Congress of Obstetricians and Gynecologists “supports the

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<sup>57</sup> See, e.g., Letter from FTC Staff to Kay Khan, Representative, Mass. House of Representatives, *supra* note 15 (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).

<sup>58</sup> IOM FUTURE OF NURSING REPORT, *supra* note 8, at 450.

<sup>59</sup> 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](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/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).

<sup>60</sup> See ASS’N OF AM. MED. COLLS., *supra* note 59 (noting impact of physician shortfalls to be “most severe” in rural and other underserved areas); see also HRSA PHYSICIAN WORKFORCE REPORT, *supra* note 59, 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 8, 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.].

<sup>61</sup> MEIT ET AL., *supra* note 60, 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).

<sup>62</sup> MEIT ET AL., *supra* note 60, 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).

<sup>63</sup> IOM FUTURE OF NURSING REPORT, *supra* note 8, 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

full scope of practice for CNMs.”<sup>64</sup> 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.”<sup>65</sup> 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”<sup>66</sup>—an approach that FTC staff believe would be consistent with the procompetitive principles outlined above.

#### IV. CONCLUSION

FTC staff support policy reforms, such as those in H.B. 177, to remove undue barriers to the provision of health care services by qualified and licensed APRNs. We strongly believe that independent APRN practice authority can help improve access to care, contain costs, and expand innovation in health care delivery.

Respectfully submitted,

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Enclosure

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D. Hodnett et al., *Continuous Support for Women During Childbirth*, COCHRANE DATABASE OF SYSTEMATIC REV. 7(3) (2007)).

<sup>64</sup> Am. Cong. of Obstetricians & Gynecologists Comments to the Fed. Trade Comm’n, Apr. 30, 2014.

<sup>65</sup> 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).

<sup>66</sup> *Id.*