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

Office of Policy Planning
Bureau of Economics
Bureau of Competition

May 5, 2014

Hon. Jeanne Kirkton
Missouri House of Representatives
State Capitol – Room 135BC
Jefferson City, MO 65101-6806

Dear Representative Kirkton:

The staffs of the Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] appreciate the opportunity to respond to your invitation for comments on Missouri House Bills 1481 and 1491 ("HB1481" and "HB1491," respectively) and their companion Missouri Senate Bills (collectively, "the Bills").[2] The Bills would amend certain statutory requirements for "collaborative practice arrangements" between Missouri physicians and advanced practice registered nurses ("APRNs"). For the reasons discussed below, we think the Bills offer several procompetitive and pro-consumer benefits.

The competitive implications of various types of APRN regulations, including mandatory collaborative practice arrangements, were analyzed in the attached March 2014 FTC staff policy paper.[3] As explained in the policy paper, FTC staff recognize the critical importance of patient health and safety, and we defer to state legislators to survey the available evidence, determine the optimal balance of policy priorities, and define the appropriate scope of practice for APRNs and other health care providers. At the same time, we observe that undue regulatory restrictions on APRN practice can impose significant competitive costs on health care consumers and other payors. Hence, we have urged state legislators to avoid restrictions on APRN practice that do not address well-founded patient safety concerns. "Based on substantial evidence and experience, expert bodies have concluded that ARPNs are safe and effective as independent providers … within the scope of their training, licensure, certification, and current practice."[4] In particular, we

[1] This letter expresses the views of 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 ("Commission") or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Letter from Hon. Jeanne Kirkton, Missouri House of Representatives, to Susan S. DeSanti, FTC Office of Policy Planning (Feb. 18, 2014).

[3] FED. TRADE COMM'N STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014), http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [hereinafter FTC STAFF POLICY PERSPECTIVES].

[4] *Id.* at 2.

suggest that "[m]andatory . . . collaborative practice agreement requirements are likely to impede competition among health care providers . . . leading to decreased access to health care services, higher health care costs, reduced quality of care, and less innovation in health care delivery.[5]

We hope you will keep these considerations in mind as you evaluate the Bills.

Discussion

I. HB1491

HB1491 would establish particular licensure requirements for APRNs, to be implemented by the Board of Nursing. HB1491 also appears to provide that APRNs may, within the scope of their practice and training, assess and diagnose patients, and order both diagnostic and therapeutic tests and procedures, without obtaining a collaborative practice arrangement with a particular physician.[6]

Section III of the FTC staff policy paper discusses in detail the potential competitive harms from overly restrictive APRN physician supervision requirements, and also identifies the types of mandatory collaboration arrangements that often amount to *de facto* physician supervision requirements.[7] In brief, the policy paper suggests that:

1) supervision or "collaborative practice" requirements exacerbate well-documented provider shortages that could be mitigated by expanding APRN practice;

2) such requirements may increase health care costs and prices;

3) rigid statutory requirements may needlessly constrain innovation in health care delivery; and

4) such mandates do not appear necessary to achieve the benefits of coordinated care.

[5] *Id.* at 37.

[6] Within the scope of APRN practice, HB1491 would permit, among other things, "(a) Patient assessment that leads to advanced diagnosis . . . ; (b) Ordering diagnostic and therapeutic tests and procedures; (c) Performing tests and procedures within the scope of practice and interpreting and using results to further patient care; (d) Ordering treatments consistent with specialty population training . . . and using nursing, medical, therapeutic, and corrective measures to treat illness and improve health status; . . . and (g) Ordering appropriate medications in accordance with prescriptive authority." HB1491, Section A, amending MO. REV. STAT. § 335.016. Nothing in HB1491 requires that an APRN enter into a collaborative practice agreement. HB1491 does stipulate a revision to MO. REV. STAT. § 335.019.2., such that "[a]ll licensed APRNs are authorized to: (1) Prescribe and institute medication therapy within such APRN's practice and specialty ...." It is unclear, however, how this provision will be read in conjunction with MO. REV. STAT. § 338.198, which could be read to require a collaborative practice agreement before a pharmacist may fill a prescription from an APRN, notwithstanding other provisions of Missouri law.

[7] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 18-38.

First, the United States faces a substantial and growing shortage of physicians, especially in primary care.[8] As a result, for many Americans, including some in Missouri, access to basic health care services may be limited, especially in poor or rural areas.[9] According to the Missouri Department of Health and Senior Services, "[h]ealth care resources in rural Missouri are limited, even for those who have health insurance, have no financial difficulty, and have access to transportation. . . . As regards access to primary health care services, the vast majority of rural counties are designated as Health Professional Shortage Areas (HPSAs)."[10] Across the country, 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."[11]

Second, APRNs tend to provide care at lower cost than physicians when they are not subject to unnecessary regulatory requirements. Maintaining undue legal or regulatory hurdles may raise the costs of APRN services, reducing supply and further diminishing access to basic primary care. Moreover, both patients and third-party payors are harmed to the extent that costs are instead passed along as higher prices.[12] In contrast, when the regulatory costs of APRN services decline (e.g., by removing particular collaborative practice requirements), the supply of professionals willing to offer those services at any given price is likely to increase. In underserved areas and for underserved populations, the benefits of expanding supply are clear: consumers are likely to gain access to services that otherwise would be unavailable.[13] Even in well-served areas, a supply expansion will tend to lower prices and drive down health care costs.[14]

Third, "rigid supervision [and collaborative arrangement] requirements may impede, rather than foster, development of effective models of team-based care."[15] 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 collaboration to promote quality

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[8] *Id.* at 20.

[9] *Id.* at 21.

[10] MELISSA VAN DYNE ET AL., MISSOURI DEP'T HEALTH AND SENIOR SERVS., HEALTH IN RURAL MISSOURI: BIENNIAL REPORT, 2012-2013, 4-5 (2014) ("Of the 101 rural counties, 98 are Primary Medical HPSAs.").

[11] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 25.

[12] *Id.* at 27-28.

[13] "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." *Id.* at 20 (citing, e.g., INST. OF MED., NAT'L ACAD. OF SCIENCES, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 98-103, 157- 61 annex 3-1 (2011) [hereinafter IOM FUTURE OF NURSING REPORT]; 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; NAT'L GOVERNORS ASS'N, NGA PAPER: THE ROLE OF NURSE PRACTITIONERS IN MEETING INCREASING DEMAND FOR PRIMARY CARE (2012), http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf [hereinafter NGA PRIMARY CARE PAPER]).

[14] The National Governors Association recognized the impact of this supply expansion in its NGA PRIMARY CARE PAPER, *supra* note 13.

[15] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 34.

of care, satisfy their business objectives, and comply with applicable regulatory requirements. New models of collaboration represent an important form of innovation in health care delivery. Proponents of team-based care have recognized the importance of this type of innovation, given the myriad approaches to team-based care that may succeed in different practice settings.[16] 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."[17]

Fourth, we have seen no evidence that statutory collaborative practice agreement requirements are necessary to achieve the benefits of team-based health care. On the contrary, as noted above, rigid supervision and collaboration requirements may impede, rather than foster, development of effective models of team-based care.[18] Collaboration between APRNs and physicians is common in all states, including those that permit APRNs to practice without mandatory collaborative practice agreements.[19] 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.[20] HB1491 would maintain state-level APRN oversight to ensure safe and responsible practice within a variety of care delivery settings, including a requirement of collaboration and referral to meet patients' needs.

HB1491 appears consistent with FTC staff's recommendation that state legislators avoid imposing restrictions on APRN scope of practice, unless those restrictions are necessary to address well-founded patient safety concerns. As noted above, "[b]ased on substantial evidence and experience, expert bodies have concluded that ARPNs are safe and effective as independent providers of many health care services within the scope of their training, licensure, certification, and current practice."[21]

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[16] *Id.* at 31 (citing Pamela Mitchell et al., Nat'l Acad. of Sciences, Inst. of Med. Discussion Paper, *Core Principles & Values of Effective Team-Based Health Care* (2012), http://www.iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/VSRT-Team-Based-Care-Principles-Values.pdf (IOM-sponsored inquiry into collaborative or team-based care)).

[17] *Id.* at 32.

[18] *Id.* at 34 (citing INST. OF MED., NAT'L ACAD. OF SCIENCES, DELIVERING HIGH QUALITY CANCER CARE: CHARTING A NEW COURSE FOR A SYSTEM IN CRISIS, 171-81 (2013) (discussing importance of and different approaches to team-based care in cancer treatment, and roles of APRNs)). Regarding the evolution and diversity of team-based care, see generally, Pamela Mitchell et al., Nat'l Acad. of Sciences, Inst. of Med. Discussion Paper, *Core Principles & Values of Effective Team-Based Health Care* (2012), http://www.iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/VSRT-Team-Based-Care-Principles-Values.pdf.

[19] Regarding diverse practice settings and collaboration, see IOM FUTURE OF NURSING REPORT, *supra* note 13, at 23, 58-59, 65-67, 72-76; *see generally* Mitchell et al., *supra* note 18.

[20] 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.

[21] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 3 (citing, e.g., IOM FUTURE OF NURSING REPORT, *supra* note 13, at 98-99; NGA PRIMARY CARE PAPER, *supra* note 13, at 7-8; EIBNER ET AL., RAND HEALTH REPORT, *supra* note 13).

II. HB1481

HB1481 amends several of Missouri's current requirements for collaborative practice arrangements. In particular, HB1481 permits "effective electronic collaboration" between an APRN and a physician, instead of stipulating a particular physical distance between them; and HB1481 permits a collaborating physician to review an APRN's records via electronic chart review.[22] We see several potential benefits of HB1481 with respect to innovation in the adoption of health information technology, although we note that HB1481 would operate within the confines of mandatory collaborative practice arrangements, about which we have raised significant competitive concerns. It is therefore likely to be less beneficial for competition and consumers than HB1491.

Health information technology is expanding rapidly, and the development of new models of basic care delivery (including retail clinics staffed primarily by APRNs)[23] creates an even greater need to facilitate efficient exchanges of health information among various health care providers. Effective electronic communication and chart review represent the type of innovative response to developments in health care delivery that FTC staff encourages in its policy paper.[24]

It is also possible that HB1481 would lower the costs of the collaborative practice arrangements now required under Missouri law. First, even established collaborations might find it more efficient to carry out some of their communications and chart review electronically, rather than in person. Second, by removing arbitrary geographic constraints on collaboration agreements, HB1481 may facilitate competition in collaboration, permitting APRNs and physicians to form more effective and efficient collaboration agreements.[25] Regarding the types of geographic limits addressed in HB1481, the policy paper notes:

> FTC staff have seen some evidence that the costs of collaborative practice agreements, including prices paid by APRNs to physicians, may be especially high in markets exhibiting certain characteristics. For example, APRNs may find it particularly difficult to form such contracts in rural or other underserved areas where collaborating physicians are in short supply.[26]

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[22] HB1481, amending MO. REV. STAT. § 334.104.3.

[23] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 33.

[24] *Id.* at 3-4.

[25] "[R]estrictions on the permissible physical distance between APRNs and supervising doctors may restrict providers' ability to develop new models of networked or telemedicine-facilitated collaboration." FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 32-33 (citing Comment from FTC Staff to the Hon. Daphne Campbell, Fla. House of Representatives (Mar. 22, 2011), http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf; MO. CODE REGS. ANN. tit. 20 § 2150-5.100 (2) (A)-(B)).

[26] FTC STAFF POLICY PERSPECTIVES, *supra* note 3, at 30.

Permitting effective electronic collaboration without arbitrary distance limits may help alleviate this problem in Missouri, as APRNs and physicians would be able to bypass local shortages and look elsewhere in the state for effective, and competitively priced, collaborators.

Conclusion

To promote competition in health care markets, it may be important to scrutinize relevant safety and quality evidence to determine whether or where legitimate safety concerns exist and, if so, whether mandatory collaborative practice requirements are likely to address them. To that end, FTC staff have looked to the findings of the Institute of Medicine and other expert bodies on issues of APRN safety, effectiveness, and efficiency. Based on their findings and our own reviews of pertinent literature, mandatory collaborative practice agreements do not appear to be justified by legitimate health and safety concerns, which is why we believe HB1491 may offer significant benefits for Missouri health care consumers. We hope you will carefully consider this body of research when considering whether there is adequate countervailing evidence to justify maintaining Missouri's current collaborative practice requirements.

Further, we hope you will consider that both HB1491 and 1481 would eliminate statutory requirements that may impose substantial competitive costs on health care providers and deter procompetitive innovation in health care delivery, to the ultimate detriment of Missouri health care consumers, as well as both public and private third-party payors.

We appreciate your consideration of these issues, and we hope the attached FTC staff policy paper will be helpful in your deliberations.

Respectfully submitted,

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