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

Office of Policy Planning
Bureau of Competition
Bureau of Economics

November 2, 2015

The Hon. Jenny A. Horne
South Carolina House of Representatives
308-D Blatt Building
Columbia, SC 29201

Dear Representative Horne:

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 the likely competitive impact of House Bills 3508 and 3078 ("H.3508" and "H.3078," respectively).[2] H.3508 would impose additional supervision requirements on most categories of advanced practice registered nurses ("APRNs"). In particular, H.3508 would require regulatory approval of a written "practice agreement" with a supervising physician for every nurse practitioner ("NP"), certified nurse midwife ("CNM"), and clinical nurse specialist ("CNS") practicing in South Carolina. H.3078, in contrast, would remove certain supervision requirements now imposed on those APRNs under South Carolina law, thereby permitting APRNs to diagnose conditions, order tests and therapeutics, and issue written prescriptions, without necessarily establishing a formal supervisory agreement with a particular South Carolina physician.[3] Removing the current supervision requirements may offer significant benefits to South Carolina health care consumers and third-party payors, absent well-founded health or safety concerns that would otherwise justify maintaining or enhancing them.

The competitive implications of various types of APRN regulations, including mandatory collaborative practice agreements, are analyzed in the attached 2014 FTC staff policy paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses*.[4] As explained in the policy paper, we recognize the critical importance of patient health and safety, and we defer to state legislators to determine the best balance of policy priorities and to 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 – patients – as well as both public and private third-party payors. The staff policy paper observes, in particular, that state-mandated practice agreements raise considerable competitive concerns and may frustrate the development of innovative and effective models of team-based health care.[5]

For these reasons, we urge the South Carolina legislature to avoid restrictions on APRN practice that are not narrowly tailored to address well-founded patient safety concerns. Expert

bodies, such as 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] We urge you to review the pertinent evidence and examine carefully any purported safety justifications for South Carolina's current APRN supervision requirements; evaluate whether such justifications are well founded; and consider whether less restrictive alternatives would protect patients without imposing undue burdens on competition and patients' access to basic primary care services. Correspondingly, we urge you to scrutinize any purported safety shortcomings in existing South Carolina APRN supervision requirements and consider whether additional requirements, such as those proposed in H.3508, are necessary to protect patients. If there are not good grounds to impose across-the-board supervision restrictions on services performed by APRNs, removing the restrictions may offer significant benefits to South Carolina's health care consumers.

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 staff policy paper, FTC staff have analyzed the likely competitive effects of proposed APRN regulations in other states, observing that removing excessive supervision requirements can achieve significant consumer benefits.[13]

II. HOUSE BILLS 3078 AND 3508

H.3078 proposes numerous amendments to South Carolina statutory provisions governing advanced practice nursing. Collectively, these changes would permit what is sometimes termed "independent practice" by APRNs in South Carolina.[14] In particular, amendments to Section 40 of the South Carolina Code would strike requirements that NPs, CNMs, and CNSs provide evidence of "approved written protocols" to practice under the supervision of a specific licensed physician.[15]

H.3508 also proposes numerous amendments to South Carolina statutory provisions governing advanced practice nursing. Among other things, H.3508 would replace current requirements for "approved written protocols" with analogous requirements for a "written practice agreement" between a NP, CNM, or CNS and a supervising physician as a prerequisite for basic areas of advance nursing practice.[16]

A key difference between the proposed "agreement" and the current "protocol" requirements would be the creation of a new layer of regulatory approval for all such agreements. Whereas South Carolina law currently requires that protocols be "made available … for review within seventy-two hours of request,"[17] H.3508 would require that practice agreements be submitted to, and approved by, a regulatory committee, "prior to initiating

practice pursuant to the practice agreement."[18] In addition, H.3508 would require an APRN to notify that committee, and receive approval of a new agreement, any time the APRN "desires to change practice settings or to change supervising physicians," and to cease practice if a written practice agreement were terminated "for any reason" – including, presumably, the retirement, suspension, impairment, or death of a supervising physician.[19] In brief, on top of general licensure and certification requirements, APRNs could not practice without first obtaining regulatory approval of their practice agreements. Moreover, a duly licensed APRN – under various conditions, including relocation *within* the state – would be required to cease practice until he or she could obtain a new practice agreement and, again, secure the regulator's approval.

III. LIKELY COMPETITIVE IMPACT OF H.3508 AND H.3078

FTC staff recognize that certain professional licensure requirements and scope of practice restrictions can be important to patient welfare.[20] Consistent with patient safety, however, we urge legislators to consider the potential benefits of enhanced competition that H.3078 may facilitate and H.3508 may impede. 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, South Carolina health care consumers are likely to benefit from lower costs, additional innovation, and improved access to health care.

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 practice agreements proposed by H.3508.[21] The policy paper analyzes four issues of particular relevance to H.3508 and H.3078. First, the United States faces a substantial and growing shortage of physicians, especially in primary care.[22] As a result, many Americans may face limited access to basic health care services, especially in poor or rural areas.[23] Research suggests that South Carolina, specifically, faces such access problems. All 46 South Carolina counties contain at least one area or population designated as a primary care health professional shortage area ("HPSA") and many of those counties are wholly designated HPSAs.[24] As a report by the South Carolina Office for Healthcare Workforce Analysis and Planning observed,

> South Carolina still trails the rest of the United States in the balance between the number of actively practicing physicians and our population numbers. In 2009 South Carolina was ranked … only 43rd in the number of actively practicing primary care physicians.[25]

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."[26]

Second, APRNs tend to provide care at lower cost than physicians. Undue legal or regulatory hurdles may raise the costs of APRN services, reduce supply and further diminish access to basic primary care. Moreover, both patients and third-party payors are harmed to the extent that higher costs are passed along.[27] 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 may gain access to services that otherwise would be unavailable.[28] Even in well-served areas, a supply expansion tends to lower prices and drive down health care costs.[29]

Third, "rigid supervision [and collaborative agreement] requirements may impede, rather than foster, development of effective models of team-based care."[30] 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. 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.[31] 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."[32]

For example, H.3508 stipulates that, "[a] written practice agreement may not authorize an APRN to perform a medical act, task, or function that is outside the usual practice of the physician."[33] While this limitation might appear to provide assurance that a particular physician is competent to supervise an APRN's practice, it raises at least two concerns. First, ambiguity regarding what lies "outside the usual practice of the physician" may tend to unnecessarily limit the scope of such practice agreements or discourage their formation. Second, the restriction would appear to limit the scope of each APRN's practice to the "usual practice" of a single physician, even if additional consulting or supervisory expertise might be readily available via collaborating physicians within an institutional health care provider or another source.

Fourth, FTC staff is unaware of evidence that statutory practice agreement requirements are necessary to achieve the benefits of team-based health care. On the contrary, as noted above, rigid legal or regulatory requirements may impede, rather than foster, development of effective models of team-based care.[34] Collaboration between APRNs and physicians is common in all states, including those that permit APRNs to practice independently.[35] 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.[36]

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.[37] Based on an intensive 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."[38] 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.[39] The report noted the high quality of primary care services provided by APRNs, who "may be able to mitigate projected shortages of primary care services."[40]

FTC staff recognize the critical importance of patient health and safety. None of the forgoing discussion is meant to downplay the valid health and safety concerns reflected in many state regulations governing health care professionals. As noted above, 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. As the South Carolina legislature engages in this exercise, however, we urge that it carefully consider the findings of the IOM and other expert bodies – findings based on decades of research and experience – on issues of APRN safety, effectiveness, and efficiency.[41] Based on an extensive review of the safety literature, the IOM has recommended that state laws permit nurses to practice to the full extent of their education, training, and experience.[42]

We encourage South Carolina legislators to review available empirical literature, as well as evidence from states with less restrictive APRN supervision requirements, particularly when assessing continued reliance on broad statutory supervision requirements. The 2011 IOM Report noted that 16 states and the District of Columbia allow APRNs to practice and prescribe independently, and that no differences in safety and quality had been associated with the adoption of state laws that permit APRNs to practice independently.[43] At present, 21 states and the District of Columbia permit APRNs to practice and prescribe independently,[44] and we continue to see no evidence of a decline in safety or quality associated with the adoption of independent practice.

IV. CONCLUSION

H.3078 would streamline APRN regulation and permit APRNs to fully utilize their education and experience to serve the needs of South Carolina health care consumers. APRNs would remain subject to regulatory oversight, but without certain formal physician supervision requirements now imposed under South Carolina law. Absent countervailing safety concerns regarding APRN practice, removing these supervision requirements has the potential to benefit consumers by improving access to care, containing costs, and expanding innovation in health care delivery. In contrast, H.3508 would maintain supervision requirements that many states have done without or eliminated, and would add a new layer of bureaucratic process to meeting those requirements. Accordingly, we encourage you to consider whether these requirements are necessary to assure patient safety in light of your own regulatory experience, the findings of the IOM and other expert bodies, and the experience of other states. Removing unnecessary and burdensome requirements may benefit South Carolina consumers by increasing competition among health care providers.

Respectfully submitted,

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Deborah Feinstein, Director
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[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 or of any individual Commissioner. The Commission, however, has voted to authorize us to submit these comments.

[2] Letter from Jenny A. Horne, Representative, S.C. House of Representatives, to Marina Lao, Dir., Office of Policy Planning, Fed. Trade Comm'n (July 21, 2015) (on file with Office of Policy Planning).

[3] Both H.3508 and H.3078 leave in place current South Carolina requirements that certified registered nurse anesthetists ("CRNAs") – a fourth major category of APRNs – practice pursuant to "'[a]pproved written guidelines' . . . specific statements developed by a certified registered nurse anesthetist and a supervising licensed physician or dentist or by the medical staff within the facility where practice privileges have been granted." S.C. Code Ann. § 40-33-20(20). For FTC staff analyses of regulatory proposals regarding CRNAs, *see, e.g.*, Letter from FTC Staff to 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/140123massachusettnursesletter.pdf (regarding supervisory requirements for nurse practitioners and nurse anesthetists); Letter from FTC Staff to Heather A. Steans, Senator, Ill. State Senate (Apr. 19, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-heather.steans-illinois-state-senate-concerning-illinois-senate-bill-1662-and-regulation-certified/130424illinois-sb1662.pdf (concerning the regulation of CRNAs); Letter from FTC Staff to Jeanne Kirkton, Representative, Mo. House of Representatives (Mar. 27, 2012), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-representative-jeanne-kirkton-missouri-house-representatives-concerning/120327kirktonmissouriletter.pdf (concerning the regulation of CRNAs).

[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 PERSPECTIVES].

[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 PERSPECTIVES, *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* FED. TRADE COMM'N, COMPETITION IN THE HEALTH CARE MARKETPLACE, 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 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, In re Ciprofloxacin Hydrochloride Antitrust Litigation, 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.*, Letter from FTC Staff to 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 Jeanne Kirkton, Representative, Mo. House of Representatives (May 5, 2014), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2014/05/ftc-staff-comment-missouri-house-representatives; Letter from FTC Staff to Kay Khan, *supra* note 3; 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 (concerning the likely competitive impact of legislation on 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 ("The Review of West Virginia Laws Governing the Scope of Practice for Advanced Practice Registered Nurses and Consideration of Possible Revisions to Remove Practice Restrictions"); 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 (concerning the likely competitive impact of legislation on APRNs).

[14] The phrase "independent practice" here, and commonly, refers to state regulatory schemes that do not require direct supervision of an APRN by a particular physician for an APRN to deliver services otherwise within his or her scope-of-practice. "Independent practice" does not, however, mean isolated or unregulated practice. Collaboration and professional oversight are the norm in states that do not require direct physician supervision. Patterns of collaboration are independently established by institutional providers, from large hospital systems to small physician practices, to individual practitioners, with the particulars varying according to resources and demands at the point of service, and standards of care, as well as other regulations. It has been reported that more than half of all nurse

practitioners are employed in private physician practices (27.9%) or hospitals (24.1%), among other institutional provider settings. John K. Iglehart, *Expanding the Role of Advanced Practice Nurse Practitioners – Risks and Rewards*, 368 N. ENGL. J. MED. 1935, 1937 (2013). Regarding diverse practice settings and APRN collaboration, see IOM FUTURE OF NURSING REPORT, *supra* note 7, at 23, 58-59, 65-67, 72-76; regarding the evolution and diversity of team-based care, 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).

[15] Striking, *e.g.*, S.C. Code Ann. § 40-33-34(c)-(d) (requiring "approved written protocols" for NP, CNM, and CNS practice and specifying terms for such protocols) and S.C. Code Ann. § 40-33-20(23) (defining basic acts of formulating a diagnosis, initiating, continuing, and modifying therapies, and prescribing drug therapy as "delegated medical acts" that must be contemplated in a written protocol and supervised by the physician named in the protocol).

[16] H.3508 proposed Section 40-47-320(A).

[17] S.C. Code Ann. § 40-33-34(D)(2).

[18] H.3508 proposed Section 40-47-320(B).

[19] H.3508 proposed Sections 40-47-320(D) and (F).

[20] 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), *available at* http://www.ftc.govibe/consumerbehavior/docs/reports/CoxFoster90.pdf.

[21] FTC STAFF POLICY PERSPECTIVES, *supra* note 4, at 18-38.

[22] *Id.* at 20.

[23] *Id.* at 21.

[24] *HPSA Find*, U.S. DEP'T HEALTH & HUMAN SERVS.: HRSA DATA WAREHOUSE, http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFind.aspx (search "South Carolina," "All Counties," "Primary Care," for listing of HPSAs county by county).

[25] *Physicians Data*, OFFICE FOR HEALTHCARE WORKFORCE ANALYSIS AND PLANNING, http://officeforhealthcareworkforce.org/showAll.php?prof=Physicians.

[26] FTC STAFF POLICY PERSPECTIVES, *supra* note 4, at 25.

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

[28] "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 4, at 20 (citing, *e.g.*, IOM FUTURE OF NURSING REPORT, *supra* note 7, 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; 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]).

[29] The National Governors Association recognized the impact of this supply expansion in its NGA PRIMARY CARE PAPER, *supra* note 28.

[30] FTC STAFF POLICY PERSPECTIVES, *supra* note 4, at 34.

[31] *Id.* at 31 (citing Pamela Mitchell et al., *supra* note 14 (IOM-sponsored inquiry into collaborative or team-based care)).

[32] *Id.* at 32.

[33] H.3508 proposed Section 40-47-320(G).

[34] FTC STAFF POLICY PERSPECTIVES, *supra* note 4, at 34 (citing INST. OF MED., NAT'L ACAD. SCI., 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*, Mitchell et al., *supra* note 14.

[35] 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* Mitchell et al., *supra* note 14.

[36] 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.

[37] *See generally* IOM FUTURE OF NURSING REPORT, *supra* note 7 (especially Summary, 1-15).

[38] *Id*. at 4.

[39] 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*].

[40] *Id.* at 11.

[41] *See* IOM FUTURE OF NURSING REPORT, *supra* note 7, at 98-99 (citing, *e.g.*, S.A. Brown & D. E. Grimes, *A Meta-analysis of Nurse Practitioners and Nurse Midwives in Primary Care*, 44(6) NURSING RESEARCH 332 (1995); S.W. Groth et al., *Long-term Outcomes of Advanced Practice Nursing*, in NURSE PRACTITIONERS: EVOLUTION AND FUTURE OF ADVANCED PRACTICE (5th ed., E. M. Sullivan-Marx et al., eds. 2010); P.F. Hogan et al., *Cost Effectiveness Analysis of Anesthesia Providers*, 28 NURSING ECONOMIC$ 159 (2010); S.E. Horrocks et al., *Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BMJ 819 (2002); F. Hughes et al., *Research in Support of Nurse Practitioners*, in NURSE PRACTITIONERS: EVOLUTION AND FUTURE OF ADVANCED PRACTICE (5th ed., E. M. Sullivan-Marx et al., eds. 2010); M. Laurant et al., *Substitution of Doctors by Nurses in Primary Care*, 2 Cochrane Database of Systematic Reviews, CD001271 (2004); M.O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A randomized Trial*, 283 JAMA 59 (2000); OFFICE OF TECH. ASSESSMENT, U.S. CONG., HEALTH TECH. CASE STUDY 37, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS (1986)); *see also* Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 1, 18 (2011) ("APRNs provide effective and high-quality patient care."); P. Venning et al., *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320 BMJ 1048 (2000) (no significant difference in patterns of prescribing or health status outcome); Christine Everett et al., *Physician Assistants and Nurse Practitioners Perform Effective Roles on Teams Caring for Medicare Patients with Diabetes*, 32 HEALTH AFFAIRS 1942 , 1945-6 (2013) (outcomes generally equivalent for NP, PA, and MD caregivers in 13 comparisons, superior for NP or PA care in 4, and superior for MD care in 3; "PAs and NPs can fill a range of roles on primary care teams, even for older patients with clinically challenging conditions such as diabetes.").

[42] IOM FUTURE OF NURSING REPORT, *supra* note 7, at 85-161; *see especially id.* at 98 (with respect to many primary care services, "the contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by the decades of research that has examined this question") (internal citations omitted).

[43] *Id.* at 98-99 (noting "[n]o studies suggest that care is better in states that have more restrictive scope-of-practice regulations for APRNs than in those that do not"). *See also* Julie A. Fairman et al., *Perspective: Broadening the Scope of Nursing Practice*, 364 N. ENGL. J. MED. 193, 194 (2011) (stating "[t]here are no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of the physician has changed or deteriorated"); *Cf.* Ateev Mehrotra et al., *Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses*, 151 ANNALS INTERNAL MED. 321, 326 (2009) (for retail clinic settings largely staffed by APRNs, analyzing 14

quality metrics for commonly treated ailments, including ear, strep, and urinary tract infections, and finding "[f]or most measures, quality scores of retail clinics were equal to or higher than those of other care settings").

[44] *State Practice Environment*, AM. ASS'N NURSE PRACTITIONERS, http://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-type.