

Reference number: P131207

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Eliason, Erica

Restrictive Scope-of-Practice Laws for Nurse Practitioners Does More Than Just Restrict Nurses

Executive Summary

Limiting the scope-of-practice for non-physician health care providers, such as nurse practitioners (NPs), limits competition for physicians, causes inefficiencies, and increases healthcare prices and spending. As an increased number of individuals will have access to healthcare with the expansion in coverage resulting from the Patient Protection and Affordable Care Act (ACA), demand is expected to increase, exacerbating the already present physician shortage. Expanding the role of NPs would help alleviate the physician shortage, drive down health care spending, and create more efficiency in the system. There are various options for expansion; however, the most efficient recommendation is for states to amend scope-of-practice laws for NPs, expanding them in such a way that is not more restrictive than necessary for patient safety and fully utilizing all of NPs' training and education. Additionally, the role of NPs could also be extended through ensuring that under Medicare, NPs are recognized and reimbursed for their services, regardless of any state's scope-of-practice laws.

Background

Scope-of-practice laws establish boundaries and regulations to control who is in charge of delivering certain medical services. State laws vary in their approach to regulating nurse practitioners (NPs) in the following fields: acting as primary care providers, diagnosing and treating independently of physicians, prescribing medication independently of physicians,

ordering physical therapy, signing death certificates, signing handicap parking permits, and signing worker's comp claims (Pearson, 2012).

Under Medicare, NP payment is set at 85 percent of the physician fee schedule amount, making them a cheaper alternative to physicians; however, current Medicare policies restrict practice opportunities and efficiency for NPs, even in states with the less restrictive scope-of-practice laws. NPs can be designated as the sole primary care provider for a Medicare patient, but they do not have the authority to place orders like home health care or durable medical equipment, limiting their ability to effectively practice without a collaborating physician (Yee et al., 2013).

Exceptions to the state NP restrictions exist under Medicare only for certain situations. NPs are recognized as primary care providers in Medicare-certified Rural Health Clinics (RHCs), and are able to perform tasks under an expanded scope with payment rates equivalent to physician payments (Yee et al., 2013). This policy was the result of provider shortages, as RHCs are located in medically underserved areas. The need for this type of exceptional policy may grow as the provider shortage increases with the addition of millions of people in the health care market.

Evidence

For years, the American Medical Association has lobbied for restrictive scope-of-practice laws for all nurses, claiming that they are protecting quality of care by doing so (AMA, 2010). The Journal of the American Medical Association published the results of a randomized control trial study involving 1316 patients conducted between August 1995 and October 1997, which compared outcomes for patients randomly assigned to nurse practitioners or physicians “for primary care follow-up and ongoing care after an emergency department or urgent care visit”

(Mundinger et al., 2000, pg. 59). The study concluded that the quality of care delivered by nurse practitioners was equal to that of physicians in all categories, including patient satisfaction, health status, and service utilization (Mundinger et al., 2000). These results refute the AMA's claims that more expansive NP scope-of-practice laws would lower the standard of care, and support the use of nurses for efficient but less costly caregiving.

Limiting the scope-of-practice for NPs results in: 1) inefficiency, 2) missed opportunities for financial savings, 3) limited competition, and 4) exacerbation of the physician shortage. Inefficiency results from restrictive scope-of-practice laws that require excessive supervision requirements. The National Institute for Health Care Reform (2013) quotes one nurse practitioner as saying: "I have to make a note, and then have to find a physician to sign it to certify that the patient still needs home care. The physician has never seen the patient, has no time to look up the information in that chart, so they totally rely on me [for my assessment of the patient]. And, I can't tell you how often that note to the physician gets lost [and creates delays for the patient]" (pg. 5). By controlling the tasks of NPs, physicians are able to keep their services more valued without challenges to the prices or method of practice – keeping prices high, competition low, and innovation stagnant.

Missed financial savings has two origins: 1) nurses are paid less, so substituting them for the higher-paid physicians will be cost-saving, and 2) competition is stifled by limiting nurse practitioners, halting efficiency and preventing maximum effectiveness, both of which keep health care costs from lowering as they would in a more competitive environment. There is some proof that physicians are protecting their status by limiting competition to keep their incomes higher. According to a study of the effects of occupational licensing requirements on wages and prices for medical services, states where it became more difficult for NPs to work

independently of physicians saw an increase in the price of healthcare when there were more limits put in place on what care could be provided by the less expensive NPs (Kleiner et al., 2014). NPs in areas with higher restrictions make less money compared to peers with wider roles, while the physicians in areas with higher NP restrictions make more money and perform more of the caregiving tasks, increasing the price for these replaced services due to physicians' higher reimbursement rates as well as for all other services, since physicians' in these areas are more expensive. The restrictive NP policies did not lead to higher healthcare quality, instead the study sheds light on areas where there is excess health spending that could be cut through substituting NPs for physicians (Kleiner et al., 2014).

Both the Health Resources and Service Administration (HRSA) and the Association of American Medical Associations (AAMC) provide estimates for the physician shortage, highlighting the potential benefits of an expanded NP role. As of January 1, 2014, HRSA had identified 6,000 "Health Professional Shortage Areas", characterized by having more than 3,500 people for every primary care physician, affecting more than 55 million residents in total. To fix the current shortage in these areas alone, at least 8,000 additional primary care physicians would be required (HRSA, 2014). The AAMC estimated a shortage of approximately 63,000 fewer physicians than will be needed in 2015, with this shortage reaching 130,600 by 2025 (AAMC, 2011). The benefits of allowing a more expansive NP role during a documented physician shortage are clear.

Problem

Requirements for physician supervision force NPs to interrupt physicians to order tests and prescriptions, causing patients to wait longer than necessary and creating delays and inefficiency in the system. This mandated collaboration is not needed to achieve high quality of

care and leads to missed opportunities for savings through limiting competition and use of the more expensive physicians when NPs could be utilized. For the sake of efficiency, cost-savings, and the growing demand for care during a physician shortage, NP roles should be re-evaluated.

Policy Options

- 1) Recommend that the FTC urge the expansion of scope-of-practice laws for NPs only in areas with higher physicians shortages

Areas with high physician shortages are in the most need of the benefits that an expansive NP role provides. Specifically targeting these areas could yield the most benefit as these areas might be more receptive to incorporating changes, given their healthcare need. To target these areas, more RHCs could be established as the number of medically underserved areas is growing. This change, however, is only minor and does not do enough to address the other problems that result from the limits on NPs. The ability to establish more RHCs might be outpaced by the growing physician shortage, leaving gaps in coverage that could only be fixed from a more exhaustive expansion of NP roles.

- 2) Leave the status quo and let the market handle these issues on its own without oversight

The ACA establishes Accountable Care Organizations (ACOs), collaborations designed to provide high quality, coordinated care to Medicare beneficiaries. Through coordination, ACOs hope to cut back on unnecessary services, introducing greater efficiency and cost-savings into the system. An ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned it. The establishment of ACOs will lead to hospitals and care providers bearing more of their healthcare costs, incentivizing them to provide care in the most efficient ways. Because of the cost-saving incentives that ACOs create, ACOs might start employing more NPs for physician roles, leaving no need for an outside party to

become involved. This solution is also only targeting part of the problem; however, and is of a particularly optimistic view about how successful ACOs will be. Additionally, it does not take into account barriers that ACOs might face in expanding the role of NPs on their own.

- 3) Recommend that the FTC urge states to expand scope-of-practice laws for NPs in states with restrictive policies, expanding them in such a way that is not more restrictive than necessary for patient safety and fully utilizes all of NPs' training and education. Additionally, recommend that Centers for Medicare and Medicaid Services (CMS) ensure that under Medicare, NPs are recognized as primary care providers, regardless of state laws

Not all plans cover services provided by NPs, creating an additional barrier to utilizing NPs. A National Nursing Centers Consortium 2009 survey found that “nearly half of the major managed care organizations did not credential nurse practitioners as primary care providers” and this lack of credentialing is a particular problem for Medicare managed care plans, because a growing percentage of the population covered under Medicare is enrolled in managed care (Cassidy et al., 2012, pg. 3). CMS could mandate that all hospitals participating in Medicare allow NPs to have certain privileges in addition to amending credentialing.

Recommendation

Policy option three, targeting both Medicare policy as well as state policies, would have the most effective impact. Urging states to expand scope-of-practice laws for NPs in states with restrictive policies at the state level will have the biggest impact on all of the problems created by limiting NPs, not just targeting the physician shortage or efficiency and cost savings in ACOs. Scope-of-practice laws should be no more restrictive than patient protection requires, “Otherwise, such limits can deny health care consumers the benefits of competition, without providing countervailing benefits” (FTC, 2014, pg. 4). Increasing the number of states with expansive NP roles will increase competition, lower prices and healthcare spending, create more

efficiency in the system, promote innovation, and alleviate the physician shortage on a larger scale.

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