



AMERICAN ACADEMY OF NURSING

transforming health policy and practice through nursing knowledge

April 29, 2014

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

RE: FTC Health Care Workshop, Project No. P131207

Dear Mr. Clark:

The American Academy of Nursing is pleased to have this opportunity to comment on the notice of the Federal Trade Commission (FTC) public workshop on "Examining Health Care Competition" and to offer comments regarding health care competition. The Academy strongly urges oversight to ensure that anticompetitive practices do not emerge that limit the roles of advanced practice registered nurses.

The Academy is composed of more than 2,200 top nursing leaders from all fifty states from education, management, research, and practice sectors. Fellows have been recognized for their extraordinary nursing careers and are among the nation's most highly-educated citizens with more than 88% holding doctoral degrees. Sixty-three percent of the fellowship works in academic settings, over 30 percent in service and practice areas, and four percent in federal and state agencies.

Ongoing changes in the health care system demand access to a full range of providers, unimpeded by unnecessary regulatory restrictions. As implementation of the Affordable Care Act continues to expand health care coverage to millions of previously uninsured Americans, it is critical that they be able to access the services of advanced practice registered nurses (APRNs--nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists). As the health care system moves greater integration of services, APRNs must be able to play a variety of roles, including providers, coordinators, managers and leaders of team-based services.

A signature initiative of the Academy is one that identifies and highlights the work of nurses who have developed practices based on innovative models of care for which there is good clinical and financial outcome data. These practices include nurse managed health centers, child birthing centers, transitional care, Programs for

All-Inclusive Care of Elderly, primary care practices that integrate behavioral health services, and more. In many of these practices, advanced practice registered nurses (APRNs--nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists) lead interprofessional teams.

Many of these “Edge Runners,” as we call these nurse innovators, have faced significant barriers in sustaining, spreading and scaling up these innovative practice models. In particular, laws and regulations that limit APRN practice serve to decrease competition, thereby decreasing individuals’ access to care and consumer choice, impeding efforts to contain costs and threatening to lower quality.

Laws and regulations in many states require physician collaboration or supervision of APRNs. Requiring collaborative agreements removes the influence of market forces and injects “rent-paying” situations. Prices for collaborative agreements remove competition, prices become inflated and not related to the services rendered. In other situations, APRNs may be unable to find a physician with whom to develop a required agreement, and thus are unable to practice. APRNs practice in many areas that are medically underserved. Additionally, there is no evidence that patient care in those states without such requirements have experienced any diminution in patient care quality. Evidence outlined in the Institute of Medicine report on *The Future of Nursing* has demonstrated that care provided by APRNs is comparable to—and sometimes better than—care provided by physicians.

In most instances, state requirements for collaboration or supervision result in generally perfunctory compliance. This should not be surprising, since APRNs are fully capable of functioning without supervision. Moreover, APRNs—like other responsible providers—regularly choose to and seek out collaborate with other professionals based on assessment of their patients’ needs. Formal statutory or regulatory requirements that dictate the specific structure and format of collaborative relationships only remove competition and add unnecessary cost and complexity to APRN practice.

Even when a collaborative agreement exists, it may operate superficially. When one nurse practitioner in South Carolina spoke publicly about the fact that her “supervising” physicians didn’t actually supervise her—similar to other nurse practitioners’ experiences in the state--both she and one of her two supervising physicians were reported to the state boards of nursing and medicine. Although the boards ultimately took no action against these professionals, such action can have an intimidating impact, chilling efforts to realistically assess artificial practice restrictions, thus impeding efforts to change them.

State requirements for collaboration or supervision also frequently have an impact on health plans’ conduct with regard to APRNs, which serve to create additional restrictions on their practice. For example, some plans will consider credentialing APRNs only if the collaborating physician is credentialed by the plan. In one upstate New York practice, a nurse practitioner now has to have two collaborating

physicians because no one physician is credentialed in all of the plans under which her patients are insured. The physicians are located over an hour away from this rural primary care provider for a panel of 2,000 patients. If the physician no longer is able or willing to collaborate, she is not permitted to see the patients. She reports that the hospitals in her region have refused to permit their affiliating physicians to sign formal practice agreements with her. While New York State recently dropped the requirement for a written agreement for experienced nurse practitioners, they must still be able to attest to having a collaborative agreement with a physician.

Language in the Affordable Care Act calls into question health plan practices that exclude APRNs from provider panels, or that create burdensome requirements that apply only to certain classes of providers (such as APRNs). Section 2706(a) of the Public Health Service Act (42 U.S.C. §300gg-5), effective January 1 of this year, provides that “a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” Implementing this provision and establishing enforcement mechanisms would be significant steps in addressing significant anticompetitive activity by health plans.

Current Medicare law requires that orders for home care or hospice care made by a nurse practitioner, clinical nurse specialist or certified nurse-midwife must be co-signed by a physician. This only serves to delay care and increase costs. Home health care providers must comply with these anticompetitive requirements in order for their services to be paid by Medicare.

Current Medicare rules require physician supervision of certified registered nurse anesthetists (CRNAs), except in states in which the governor has chosen to opt out of this requirement. This is true even if state scope of practice laws do not require supervision. This provision adds an unnecessary layer of state oversight of practice, one that is subject to different political pressures than scope of practice legislation. It contributes to an anticompetitive policy and practice climate for APRNs.

As new models of integrated care continue to develop, such as Accountable Care Organizations and Primary Care Medical Homes, it will be important to monitor practices with regard to APRN roles. Initial accreditation standards developed by the National Committee on Quality Assurance, for example, provided that only physicians could function as leaders of medical homes. (These standards were subsequently changed to allow APRNs and other non-physicians to serve as leaders).

Advanced practice registered nurses have the education and training to provide access to high quality care to the American public. Statutory prohibitions that are without merit limit the public's access to these providers.

Sincerely,

Cheryl G. Sullivan
Chief Executive Officer
American Academy of Nursing