VERMONT

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Agency of Human Services

February 8, 2018

House Government Operations Committee
Vermont General Assembly
115 State Street
Montpelier, VT 05633-5301

Re: Input for H.684, Section 13

To the Committee:

Thank you for the opportunity to testify before the Committee on February 2. I'm writing to forward you the motion passed by the Board at their meeting of February 7, 2018. The motion passed by the Board provides:

> The purpose for the Board of Medical Practice is to protect the public when receiving medical care. It is the Board's position that Section 13 of H.684 should not be enacted into law. Neither the minimal requirements to document an APRN's scope of practice in a practice guideline document, nor the requirement for an inexperienced APRN to have a collaboration agreement in place amounts to a barrier to practice or an anti-competitive measure. The statutory requirements are reasonable regulatory responses that promote practice only within those areas for which an APRN is qualified and promote the availability of a collaborating mentor for the least experienced APRNs. The requirements protect the public and are well justified.

The motion passed on a 12-1 vote. The dissenting member stated that his dissent was based on a belief that APRN supervision requirements should be stronger than the existing statutes provide. Enclosed you will find a second motion that was passed, which offers background and analysis underlying the Board's statement in the above-quoted motion. That motion passed 13-0. A copy is enclosed. This letter is also to submit some additional documents, and to provide additional written comments for your consideration. I hope that you can take a moment to review my comments, even though I testified last week. As a member of your Committee brought out last Friday, the Board had no forewarning from the Nursing Board or OPR that this was coming.

First, I ask you to consider a January 2018 opinion letter from the FTC to a member of the Pennsylvania House of Representatives. That letter provides the FTC's endorsement of Pennsylvania HB100, a bill that proposes to allow full independent practice by APRNs who have practiced for more than three years under a collaboration agreement with a physician. It would

seem that OPR erred in assessing how the FTC would view Vermont's requirement for two years' practice under a collaboration agreement, and the additional flexibility of having the option of an experienced APRN act as the collaborating professional.

I've also included a full copy of the 2014 FTC Report, *Competition and the Regulation of Advanced Practice Nurses*. OPR cited that report as condemning APRN regulatory requirements as burdensome barriers to competition and access to care. However, some key parts were overlooked. The report counsels:

Licensure and scope of practice regulations can help to ensure that health care consumers (patients) receive treatment from properly trained professionals. APRN certification and state licensure requirements should reflect the types of services that APRNs can safely and effectively provide, based on their education, training, and experience.

2014 FTC Report, 3-4 (emphasis supplied).

The practice guideline requirement in Vermont is completely in synch with that FTC guidance. In the least burdensome way possible, the Vermont law (and rule) call for submission of guidelines that reflect current standards of advanced nursing practice specific to the APRN's role, population focus, and specialty. 26 V.S.A. § 1612 does just what the FTC says state requirements should do – reflect what services an APRN can do based on education, training, and experience. The practice guideline requirement is a minimal administrative burden that allows for an APRN to practice without any other restrictions within the limits of their training and experience.

The FTC report's summary of burdensome scope-of-practice regulations is very informative. In listing burdensome requirements, it demonstrates how clear it is that Vermont's requirements are not burdensome. As noted in the report: *Some scope of practice restrictions are procedure-oriented, limiting APRNs' ability to prescribe medicines, refer for, order, or perform certain tests or procedures, or treat certain indications. Other restrictions focus on the types of patients APRNs may see. For example, APRNs may not be allowed to "examine a new patient, or a current patient with a major change in diagnosis or treatment plan, unless the patient is seen and examined by a supervising physician within a specified period of time."* FTC Report at 9-10 (footnotes omitted). The contrast between those severe limitations on scope of practice, and Vermont's requirement that APRNs simply document their scope of practice, should be apparent to even those who are unfamiliar with these matters.

Another point that must be made about the 2014 FTC Report, and its discussion of burdensome regulatory schemes, is that throughout it refers to requirements for APRN collaboration with a physician. As noted above, one of the many features that sets Vermont's requirements apart from those of states discussed as examples of burdensome, anti-competitive practices is the option for an APRN to collaborate with an APRN. If one considers the FTC's explanation of the market forces when there is competition between different professions it becomes apparent how much the option to use another APRN eliminates most of the concerns about competition – the

FTC's stated concerns about price disparities between professions, unfamiliarity with different professions, and professional bias all are mitigated or eliminated by this option.

Review of the FTC report also helps one to understand just how clear it is that Vermont's requirements for supervision are not burdensome. For an APRN who does not meet the experience requirement, 26 V.S.A. § 1613 requires no more than this of the APRN: *shall have a formal agreement with a collaborating provider as required by board rule*. Then, in its entirety, the BoN Rule states: ***8.16 Collaborating Provider Responsibilities*** *A collaborating provider shall: (a) review, sign, and date the APRN's practice guidelines; (b) serve as an advisor, mentor, and consultant to the APRN; (c) participate in quality assurance activities.* That is not a restriction or a barrier to practice.

The FTC report abounds with examples of burdensome, restrictive requirements: *Physician supervision may be required for all APRN practice, or for particular practice activities such as prescribing medications. Supervision rules sometimes define the parameters of supervision more specifically. Some require that APRN patient charts be reviewed at some particular frequency; some limit the number of independent APRNs one physician may supervise, or restrict the physical distance permitted between a supervising physician and a supervised APRN. Florida law, for example, imposes broad supervision requirements on APRN practice, while also specifying that an APRN cannot practice more than a certain distance from the primary place of practice of his or her supervising physician.* FTC Report, 10-11 (footnotes omitted). More examples in the report are: a requirement that a collaborating physician share patients with the APRN; restrictions on the number of APRNs that a physician may supervise; limitations on the physical distance that a supervising doctor may be from an APRN. FTC Report, pages 32-33.

The best evidence that the Vermont requirements are not burdensome or overly restrictive is the lack of any evidence of negative impacts. <u>After more than five years under the present system, there was no evidence of an APRN who has been unable to find a professional to provide collaboration</u>. The one story offered was about an APRN who had difficulty obtaining a collaborating professional, but in the end succeeded. Importantly, it was not the statute, but the BoN rule that caused the problem for the lone APRN cited as having a problem with this. It was because the BoN rule is rigid and includes no provision for a pathway to a waiver or other alternatives that might have avoided that problem. Perhaps rather than throwing out a statute that is aimed at protecting the public by promoting support for very inexperienced APRNs, the rule might be adjusted to reduce the likelihood of replication of that issue.

One last point about the FTC Report. It plainly states the FTC's viewpoint that when burdensome or anti-competitive APRN regulation restricts APRN access to the healthcare marketplace it reduces competition, and:

[t]his reduction in competition may exacerbate provider shortages and thereby contribute to access problems, particularly for underserved populations that already lack adequate and cost-effective primary care services.
FTC Report, 20.

Data shows that Vermont has avoided the worst of the access-to-care problems seen in many parts of the country. By one measure, as of 2016, Vermont could eliminate its Health Professional Shortage Areas (HPSA) with the addition of one primary care provider, and only about 10,000 Vermonters live in an HPSA. Kaiser Family Foundation, HPSA Table as of December 31, 2016. Given Vermont's position as compared to many other states, the data appear to show that the minimal regulation of APRNs has not caused any harm to the healthcare marketplace. Vermont compares favorably to Pennsylvania, the subject of the above-mentioned FTC endorsement of a three-year experience requirement for independent APRN practice. Pennsylvania has much greater access issues, and presumably a less competitive health care marketplace. Over 600,000 Pennsylvania residents (with a total population of between 12 and 13 million) live in one of the state's 159 HPSAs and it would require 88 additional primary care professionals (PCP) to address the problem. Roughly one in twenty Pennsylvanians lives in an HPSA, while in Vermont it's roughly one in sixty Vermonters living in an HPSA. One could justifiably be concerned that government regulation had anticompetitive impacts in Pennsylvania, but not in Vermont. In total, over 65 million Americans live in an HPSA – about one in *five* -- and it would take 8,644 PCPs to make up the shortfall. Remember, in Vermont it's about one in *sixty* living in a PCP HPSA and the calculated shortfall is one PCP.

This is not to say that we should not be concerned about access to primary care in Vermont. Vermont's goal is to have a much better PCP to population ratio than the ratio that defines a PCP HPSA. Also, we've submitted Vermont data that shows the number of physician PCPs has been in decline for several years. Fortunately, Vermont has benefited from steady growth in the APRN and physician assistant PCP workforces over the same period. VDH Scorecard for Access (available at http://www.healthvermont.gov/scorecard-health-services-access). Whether one considers the national data or the Vermont-specific data, the reasonable conclusion is that it is quite unlikely that regulation has harmed competition in the healthcare marketplace and Vermont has been successful in attracting APRNs and PAs to practice in primary care.

Please give careful consideration to the arguments offered by proponents of Section 13. Calling the APRN requirements burdensome and anticompetitive does not make them so. Consider the FTC report that we've provided – the information in there about burdensome regulations is some of the best evidence to show that the Vermont APRN requirements are neither burdensome nor anticompetitive. Consider the fact that there's no evidence that any APRN has been prevented from practicing by these requirements.

Proponents of Section 13 argued that collaboration will go on without this requirement. Yes, that is true. But the requirement does nothing to deter collaboration. The whole point is that 26 V.S.A. § 1613 provides a safety net, which ensures that the least experienced APRNs have a source for mentorship. Proponents over and over made the argument that these very inexperienced APRNs are not going to practice without collaboration. It is true that most would not. That is not the point. It is the role of the State of Vermont to protect its residents by ensuring that it cannot happen.

Any doubt about the fact that it is a public protection imperative to prevent independent practice by APRNs who lack experience is resolved when one considers the data about training. The APRN training program standard for supervised clinical training hours is 500. The UVM College of Medicine curriculum provides MD graduates 5,760 hours of supervised clinical practice, which is not unusual. Medical school graduates do not qualify for a license to practice independently in any state without additional residency training, also known as Graduate Medical Education. Vermont requires an additional two full years of GME, which consists of 3,000 to 4,000 hours per year of supervised clinical training. In all, to be eligible to be licensed to practice medicine independently, an MD must have somewhere between 12,000 and 14,000 hours of supervised clinical training. The requirements to be licensed for independent practice as an MD are not designed to be burdensome or stifle competition. The requirements are demanding because the practice of medicine is complex and demanding, and the stakes are high. When the Board revised its Rules in 2017 the minimum requirement for GME of two years was carefully considered. The Board settled on two years because it is a safety issue. As shown in the article provided to the Committee last week, *Training Matters*, an academic study revealed a startling correlation between the number of years of GME training and the likelihood of being sanctioned for a quality of care problem. The data showed an easily understood relationship: the less supervised clinical training an MD had, the greater the likelihood that they will be sanctioned. Training truly does matter.

In the end, please answer this question before you make up your mind. Should the State of Vermont allow the possibility that patients' health and safety can be in the hands of someone who has only 500 hours of supervised clinical training?

Sincerely yours,

David K. Herlihy
Executive Director

Enclosures

Vermont Board of Medical Practice Motions Approved on February 7, 2018

Letter from the FTC to the Honorable Jesse Topper, January 3, 2018

Federal Trade Commission Policy Perspectives, *Competition and the Regulation of Advanced Practice Nurses,* March 2014

Kaiser Family Foundation, HPSA Table as of December 31, 2016

Vermont Department of Health Scorecard for Access, http://www.healthvermont.gov/scorecard-health-services-access