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FEDERAL TRADE COMMISSION
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Office of Policy Planning
Bureau of Competition
Bureau of Economics

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Via USPS and email to susan.reynolds@idph.iowa.gov

Susan Reynolds
Professional Licensure Division
Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319-0075

**RE: Iowa Board of Physician Assistants, Proposed New Rules: 645—327.8:
Definition of physician supervision of a physician assistant¹**

The staffs of the Federal Trade Commission’s Office of Policy Planning, Bureau of Economics, and Bureau of Competition (“FTC staff”) ² appreciate the opportunity to respond to the request for public comments on the Iowa Board of Physician Assistants’ (“PA Board”) proposed rule, “Definition of physician supervision of a physician assistant” (“Proposed Rule”).³

Iowa patients would likely benefit if physician assistants (“PAs”) in Iowa can practice with as few restrictions as possible, consistent with their education, training, skills, and experience. PAs can provide more choice among health care providers, leading to more accessible, affordable, safe, and effective health care. Thus, FTC Staff support the PA Board’s initiative to comply with its legislative mandate to establish specific minimum standards *or* a definition of supervision ⁴ while maintaining maximum flexibility at the practice level to allow physician-owned practices, hospitals, clinics, and other practice sites to best employ PAs’ capabilities in a safe manner.

Specifically, the Proposed Rule would maintain the statutory and regulatory status quo by allowing supervising physicians and PAs flexibility to determine, implement, and document the appropriate level of supervision at the practice site. Based on FTC staff’s prior examination of the impact of professional regulations on health care provider competition, we believe the Proposed Rule would allow Iowa physicians and health care facilities to employ and deploy PAs in the most efficient and effective manner, consistent with patient safety.

In contrast, the PA Board’s previously proposed regulations, and the regulations adopted by the Iowa Board of Medicine (“BOM”), appear to limit such flexibility and impose potentially new and more costly supervision requirements.⁵ Absent evidence of public health or safety concerns about the care that PAs and their supervising physicians provide under current laws and regulations, we believe the PA Board’s Proposed Rule would likely preserve competition and

maintain and improve access to needed health care services for Iowa patients, particularly in medically underserved areas.⁶

I. INTEREST AND EXPERIENCE OF THE FTC

The FTC is charged with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁷ Competition is at the core of America's economy,⁸ 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,⁹ research,¹⁰ and advocacy.¹¹

FTC staff have submitted many comments, and published a policy paper, explaining that competition and consumers benefit if advanced practice registered nurses ("APRNs") can practice free of supervision requirements that are not justified by legitimate patient health and safety concerns.¹² Although FTC staff have not previously submitted comments focused specifically on PA supervision and scope of practice issues, our APRN comments and the APRN policy paper have suggested that a similar interplay between competition and scope of practice regulation may apply to PAs as well.¹³ This prior FTC staff work informs the review of proposed regulations in Iowa concerning PAs. The link between APRN and PA scope of practice regulation and how it may affect competition and consumers is further supported by the Centers for Medicare and Medicaid Services ("CMS"), which recently proposed regulatory revisions to eliminate certain language that had treated PAs differently than APRNs. CMS suggested that APRNs and PAs should be treated similarly with respect to their scope of practice, stating "PAs are trained on a medical model that is similar in content, if not duration, to that of physicians. Further, PA training and education is comparable in many ways to that of APRNs and in some ways, more extensive."¹⁴

II. BACKGROUND

A. Overview of the PA Profession

The PA profession emerged in the 1960s to address primary care physician shortages, as well as to train military veterans who were corpsmen and medics to provide medical care under physician oversight.¹⁵ PAs are educated in the medical model in master's level accredited programs, with the typical program of didactic and clinical education lasting 27 continuous months and including approximately 2,000 hours of supervised clinical practice.¹⁶ Approximately 108,000 PAs practice across all medical and surgical specialties nationwide, with about 30,000 PAs in primary care practice.¹⁷

PAs constitute ten percent of the primary care work force and nine percent of clinicians in community health centers, and play a significant role in staffing federally designated rural health clinics.¹⁸ The Bureau of Labor Statistics projects that the PA profession will grow over 30 percent by 2024.¹⁹ At the same time, the Association of American Medical Colleges ("AAMC") projects significant physician shortages in both primary and specialty care by 2025.²⁰ The AAMC also reported that Iowa ranked 42nd among the states in the number of active physicians per 100,000 people, 45th in the total number of active patient care physicians, and that 38 percent

of Iowa's active physicians were over the age of 60.²¹ Thus, it appears that encouraging the greater use of PAs could help to alleviate these projected physician shortages in the U.S. generally and Iowa specifically.

B. Background on PA Statutes and Regulations in Iowa

In 1988, the Iowa legislature created the PA Board and moved regulatory authority from the BOM to the PA Board.²² In taking this action, the Iowa legislature granted PAs a certain degree of regulatory autonomy over their profession, subject to specific supervisory requirements mandated by the legislature.²³

Iowa law requires that PAs be licensed and allows PAs to perform certain medical services under a physician's supervision. A physician cannot supervise more than five PAs at the same time. Several restrictions have eased over time, including an increase in the number of PAs whom a physician can supervise from two to five. The statute requires the PA Board to adopt rules "requiring a licensed physician assistant to be supervised by physicians" and states that a "licensed physician assistant shall perform only those services for which the licensed physician assistant is qualified by training or not prohibited by the board."²⁴

1. PA Board Regulations

The PA Board has adopted various regulations to implement the broad statutory requirements, as well as additional specifications governing the relationship between physicians and PAs. Existing PA Board regulations define "supervision" as follows:

[A] supervising physician retains ultimate responsibility for patient care, although a physician need not be physically present at each activity of the physician assistant or be specifically consulted before each delegated task is performed. Supervision shall not be construed as requiring the physical presence of the supervising physician at the place where such services are rendered except insofar as the physical presence is expressly required by these rules or by Iowa Code chapter 148C.²⁵

Existing regulations also require that PAs pass a national certification exam and identify their supervising physicians on board-approved forms before practicing in Iowa and when renewing their license. The regulations incorporate the statutory requirements that at least one physician must supervise a PA and that a physician cannot supervise more than five PAs at the same time. The regulations specify that it is the PA's and physician's responsibility to ensure adequate supervision, and if the designated supervisor is not available, the PA cannot practice unless a substitute physician can supervise during that time. The regulations require both the PA and the physician to know and comply with the supervision provisions and to review the PA's patient care on an ongoing basis, as appropriate based on the clinical condition of the patient.²⁶

Neither Iowa law nor existing PA Board rules require a supervising physician to review every chart or visit, and the rules allow for the review of patient care in person or via telephone or other telecommunication means. If physician signatures are necessary as part of supervision, the rules permit electronic signatures if certain safeguards are in place.²⁷ The regulations set forth

the types of medical services a physician can delegate to a PA and state that “the ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors.”²⁸

The PA Board regulations also set forth specific requirements for remote medical sites, which are defined as practice locations at which the supervising physician is present less than 50 percent of the time. For remote medical sites, the supervising physician must visit the remote site at least every two weeks, or less frequently under special circumstances that require notification to the PA Board.²⁹

2. New legislative charge to both PA Board and BOM in 2015

In 2015, the legislature adopted a provision known as Senate File 505 (“SF505”), which states:

The boards of medicine and physician assistants shall jointly adopt rules pursuant to chapter 17A to establish specific minimum standards *or* a definition of supervision for appropriate supervision of physician assistants by physicians. The boards shall jointly file notices of intended action pursuant to section 17A.4, subsection 1, paragraph “a”, on or before February 1, 2016, for adoption of such rules.³⁰ [Emphasis added].

In compliance with SF505, subcommittees of both the BOM and the PA Board worked together to develop a proposed regulation and issued notices of proposed rulemaking to set minimum standards for physician supervision of PAs.³¹ In response to public comments, both boards issued identical amended proposed rules – ARC 2531C by the PA Board and ARC 2532C by the BOM.³²

The BOM adopted ARC 2532C, the amended rule, which we discuss below. The BOM press release and other actions suggest that – despite legislative language that seems to require a jointly adopted rule – the BOM appears to consider its rule effective and enforceable³³ even without a parallel rule adopted by the PA Board.³⁴

The PA Board received additional comments on ARC 2531C, held another hearing on June 3, 2016, and held two subsequent board meetings to discuss ARC 2531C.³⁵ Based on the public comments, the PA Board expressed concern that ARC 2531C (and ARC 2532C, the identical version adopted by the BOM) would have significant adverse effects and would be likely to negatively impact access to care for Iowans.³⁶ As a result, the PA Board has issued and seeks public comment on the Proposed Rule.³⁷

III. THE PA BOARD’S CURRENTLY PROPOSED RULE

The PA Board’s Proposed Rule expands upon the existing definition of physician supervision in the PA Board’s current rules, without specifying additional minimum standards of supervision. The Proposed Rule states:

327.8(1) Definition of supervision. Supervision means an ongoing process by which a supervising physician and physician assistant jointly ensure that the medical services provided by the physician assistant are appropriate. A supervising physician retains ultimate responsibility for patient care. A physician need not be physically present at each activity of the physician assistant or be specifically consulted before each delegated task is performed. Supervision shall not be construed as requiring the physical presence of the supervising physician at the place where such services are rendered except insofar as the physical presence is expressly required by Iowa Code chapter 148C.

327.8(2) Additional elements of supervision.

- a. Supervision must be tailored to the individual practice setting and take into account the experience of both the physician and physician assistant.
- b. Individual practice requirements must guide how to best use health information technology to enhance patient care by ensuring effective and timely communication between physician and physician assistant.
- c. The supervising physician and physician assistant must determine appropriate methods of evaluation for each practice. This evaluation may include, but is not limited to, review of delegated services, periodic chart review, and existing evaluation tools as determined by the practice.
- d. Both the supervising physician and physician assistant must review all of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the Iowa Code.³⁸

IV. LIKELY IMPACT OF THE PA BOARD'S PROPOSED RULES

FTC staff recognize that certain professional licensure requirements and scope-of-practice restrictions may be necessary to protect patients.³⁹ Consistent with patient safety, however, we have urged regulators and legislators to consider whether removing unnecessary practice restrictions for non-physician providers may promote competition and benefit patients.⁴⁰ With respect to the Proposed Rule, if PAs can better practice to the full extent of their education, training, and abilities – as determined by their physician supervisors – health care consumers will likely reap competitive benefits. Those gains would flow from an expanded supply of quality health care providers, including improved access to health care, lower costs, and additional innovation.⁴¹

When analyzing competition in various health care professions, FTC staff consistently recommend that policy makers carefully examine purported safety justifications for restrictions on health care practitioners – especially when the scope of practice for one health care profession overlaps to some degree with that of another profession over which it exercises supervisory authority. We have recommended that state legislators, regulators, and other policy decision makers:

- Evaluate what, if any, pertinent evidence exists to maintain or add scope-of-practice restrictions;
- Evaluate whether purported health and safety justifications are well founded; and

- Consider whether less restrictive alternatives would protect patients without imposing undue burdens on competition and undue limits on patients’ access to health care services.⁴²

FTC staff urge the PA Board, as well as the BOM,⁴³ to apply a similar analytical framework as they consider regulations governing physician supervision of PAs. We recognize that Iowa law requires PAs to practice under the supervision of physicians. This requirement gives supervising physicians some control over PAs’ ability to access the health care marketplace, including for services where those PAs may compete with physicians.⁴⁴ But regulations to implement this legislative requirement can, and should, minimize restrictions that are not justified by legitimate patient safety concerns. Even well-intentioned laws and regulations may include unnecessary or overbroad restrictions, including those that may limit competition or frustrate the development of innovative and effective models of team-based health care.⁴⁵ Such undue restrictions on health care services can raise costs or prices to patients or third-party payers, limit access to important health care services, or both, without providing countervailing consumer protection benefits.

The PA Board’s Proposed Rule, which would promote greater flexibility and avoid a “one size fits all” approach, likely will enable physician-owned practices and clinics, as well as institutional health care providers, to continue to deploy PAs efficiently and effectively in a variety of patient care situations.⁴⁶ The Proposed Rule appears to comply with the statutory mandate in that it provides a more detailed definition of supervision, and does so without creating additional rigid supervision rules that could increase costs and decrease access. Moreover, unlike the previous proposal by the PA Board (ARC 2531C), which was adopted by the BOM (ARC 2532C), the Proposed Rule is unlikely to create confusion or uncertainty as to the regulations with which PAs and physicians must comply.

V. LIKELY IMPACT OF THE PA BOARD’S PREVIOUSLY PROPOSED ARC 2531C AND THE BOM’S ADOPTED ARC 2532C

SF505 appears to contemplate that both the BOM and the PA Board will adopt identical rules. Therefore, we think it is useful to highlight some questions and concerns related to the PA Board’s previously proposed ARC 2531C, which the BOM adopted as ARC 2532C (hereinafter collectively referred to as “ARC 2532C”). ARC 2532C would mirror the PA Board’s current definitions of supervision and remote medical sites.⁴⁷ ARC 2532C would also set forth minimum standards of supervision, which appear to impose additional requirements and restrictions compared to the existing supervisory relationship between physicians and the PAs they supervise. For example, the new BOM regulations would prescribe how or when certain supervisory functions must take place, such as face-to-face meetings and chart reviews.⁴⁸ As explained below, FTC staff question whether these additional supervisory requirements are necessary.

In addition to our substantive concerns about ARC 2532C, FTC staff also note an important procedural concern. We understand that ARC 2532C, as well as the Proposed Rule, would be considered *additional* rules that would not replace or supersede the PA Board’s currently codified regulations. Because some of the language in ARC 2532C is similar to that of

current PA Board regulations, but is not identical,⁴⁹ this layering of old and new requirements may confuse and impose costs on supervisory physicians, health care institutions, and PAs.⁵⁰

A. Face-to-Face Meetings

ARC 2532C would require at least one supervising physician to meet face-to-face with each PA a minimum of twice annually.⁵¹ Neither the Iowa statutes nor the current PA Board regulations require face-to-face meetings, with the exception of certain requirements for PAs working in remote medical sites.

FTC staff query whether there is evidence to support a requirement that formal face-to-face meetings are necessary to address any legitimate health or safety concerns with respect to the large number of PAs who collaborate routinely with physicians. The large majority of Iowa PAs work in physicians' offices, clinics, hospitals, and other health care settings where PAs and their supervising physicians interact regularly, discussing cases and issues as they occur.⁵² Public comments indicate that physicians, clinics, hospitals, and PAs are concerned that compliance with an additional face-to-face meeting requirement would add costs in terms of time, potential travel, documentation, reduced patient visits, and lost revenue.⁵³ They also raise concerns about how compliance might be achieved. For example, faculty from the Carver College of Medicine at the University of Iowa noted that University of Iowa Health Care's ("UIHC") 75 physician assistants "generally have immediate access to a staff physician for consultation at the time of the patient visit, so that PA supervision is accomplished in a manner similar to supervision of resident and fellow physicians." Yet, UIHC did not think this system would "technically meet the requirements in the proposed rule, so additional meetings would be required."⁵⁴

With respect to PAs practicing at remote sites, the current PA Board regulations already require the supervising physician to visit a remote site at least every two weeks in order "to provide additional medical direction, medical services and consultation."⁵⁵ The BOM's press release regarding ARC 2532C appears to suggest that, with respect to remote clinics, the two new required face-to-face meetings would be *in addition to* the 26 currently required visits for PAs practicing in remote clinics.⁵⁶ If so, FTC staff question whether there is a substantiated health or safety rationale for imposing this additional requirement. We also respectfully suggest that in-person, face-to-face meetings should not be mandated by legislation or regulation. Absent demonstrable evidence that face-to-face meetings are necessary to promote health care quality and protect patients, the supervising physician and supervised PA should have flexibility to determine the most effective and efficient way to maintain an appropriate supervisory relationship.⁵⁷

Even if the intent is to substitute two required face-to-face meetings per year for PAs practicing at remote sites and thereby eliminate the 26 current site visits, FTC staff note that 28 states and the District of Columbia impose no on-site or face-to-face meeting requirements for the supervision of PAs.⁵⁸ Similarly, in 2014, CMS also eliminated biweekly onsite physician visits to critical access hospitals ("CAHs"), rural health clinics ("RHCs"), and federally qualified health centers ("FQHCs").⁵⁹ In response to comments on the proposed rule implementing that change, CMS noted that:

specifying a precise timeframe for a physician to visit the CAH, RHC, or FQHC, and provide the general oversight required . . . would not guarantee better health care. With the development of technology such as telemedicine, we believe a CAH, RHC, or FQHC should have the flexibility to use a variety of ways and timeframes for physician(s) to provide the necessary medical direction and oversight.⁶⁰

CMS also estimated that removal of the on-site provision would produce estimated annual savings of approximately nearly \$75.6 million for CAHs, RHCs, and FQHCs.⁶¹

If the BOM and the PA Board nevertheless decide there is a legitimate and substantiated justification to keep the face-to-face requirement, FTC staff urge the PA Board and the BOM to consider whether meetings via telecommunications or video conferencing could address any purported health and safety concerns, while minimizing the costs and burdens for a supervising physician to travel to a remote clinic.⁶² FTC staff have submitted a number of comments supporting the increased use of telehealth by various types of health care providers under appropriate circumstances,⁶³ and we respectfully suggest to the BOM and the PA Board that telehealth consultations might be adequate substitutes for some or all visits at the remote sites.

B. Chart Reviews

ARC 2532C would require that “[e]ach supervising physician shall conduct and document an ongoing review of a representative sample of the physician assistant’s patient charts encompassing the scope of the physician assistant’s practice provided under the physician’s supervision and discuss the findings of the reviews with the physician assistant.” It appears that this chart review requirement would be a completely new imposition for most PAs and physicians in Iowa. Chart review is now required only for Iowa PAs with less than one year of experience when practicing in a remote site.⁶⁴

Twenty-eight states and the District of Columbia have no comparable chart review requirement.⁶⁵ Similarly, CMS, during its rulemaking to eliminate specified onsite visits to CAHs, RHCs, and FQHCs also chose to eliminate a specified timeframe for reviewing charts. CMS noted that it would instead allow for periodic review to provide these health care entities “with the flexibility to manage patient care activities in such a way as to maximize staff time to provide patient access to quality care in rural and remote areas.”⁶⁶

This new chart review requirement could be a confusing and costly provision, depending on whether it adds new chart review and documentation obligations beyond existing requirements for physicians, hospitals, and other health care entities in connection with physician supervision of PAs. Public comments submitted in response to the proposed rules raised these types of concerns. Many organizations (e.g., physician practices, clinics, hospitals) noted they already have chart review systems in place – some on a daily basis, and often via electronic health records – but it is unclear what else ARC 2532C might require.⁶⁷ They wondered, for example, whether organizations would have to implement entirely new systems for chart reviews, and whether a supervising physician would need to set aside time on “an ongoing basis” to talk to the PA and formally discuss chart reviews even when the supervising physician had

reviewed the course of action, agreed with everything, and initialed the chart at the time of care. In many of these organizations, if there is a question about treatment, it is handled “in the moment,” and it is unclear how ARC 2532C would require this be documented.⁶⁸

VI. CONCLUSION

FTC staff support the PA Board’s efforts to comply with the legislative mandate in SF505 by providing a definition of “physician supervision” without the additional burdens contained in previously noticed rules or those in ARC 2532C, unless there is substantiated health and safety evidence supporting such requirements. Those additional burdens could decrease access to care and potentially increase health care costs for Iowa consumers, as well as to physicians and health care institutions that employ PAs. Accordingly, we encourage the PA Board to continue its efforts, including continued collaboration with the BOM to jointly adopt the PA Board’s Proposed Rule, to improve access to care for Iowa patients as effectively and efficiently as possible.

Respectfully submitted,

Tara Isa Koslov, Acting Director
Office of Policy Planning

Ginger Jin, Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

¹ ARC 2832C, Amended Notice of Intended Action, 39 Iowa Admin. Bull. 1108 (Dec. 7, 2016) (to be codified at IOWA ADMIN. CODE r. 645-327.8(1) & (2), http://idph.iowa.gov/Portals/1/userfiles/26/PA/SECOND%20AMENDED%20NOTICE%20OF%20INTENDED%20ACTION%20-%20IAC%20327_8.pdf (establishing definition of physician supervision of a physician assistant). According to its agenda, the PA Board adopted this version at its November 15, 2016 meeting. Iowa Bd. of Physician Assistants, *Agenda* (Nov. 15, 2016), <http://idph.iowa.gov/Portals/1/Meetings/MeetingFiles/13/Agendas/4eec981c-0db4-4c26-aba8-ada213aad4a3.pdf>.

² This letter expresses the views of staff in 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 authorized us to submit these comments.

³ ARC 2832C, Amended Notice of Intended Action, *supra* note 1.

⁴ See discussion concerning statutory and regulatory background, *infra* at Section II.B.2.

⁵ 38 Iowa Admin. Bull. 2169, 2162 (May 11, 2016) (PA Board proposed ARC 2531C and Notice of PA Board’s June 3, 2016, Public Hearing on the proposed regulations).

⁶ See generally INST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH (2011), <https://www.nap.edu/catalog/12956/the-future-of-nursing-leading-change-advancing-health> [hereinafter IOM]

FUTURE OF NURSING REPORT]; *see id.* at 98 (noting that the “growing use of APRNs and physician assistants has helped ease access bottlenecks, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases.”); OFFICE OF TECH. ASSESSMENT, U.S. CONG., HEALTH TECH. CASE STUDY 37, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE- MIDWIVES: A POLICY ANALYSIS 39 (1986), <https://www.princeton.edu/~ota/disk2/1986/8615/8615.PDF> (“Most observers conclude that most primary care traditionally provided by physicians can be delivered by [nurse practitioners and physician assistants].”).

⁷ 15 U.S.C. § 45.

⁸ *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.”).

⁹ *See, e.g., Competition in the Health Care Marketplace*, FED. TRADE COMM’N, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>.

¹⁰ *See, e.g., 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>.

¹¹ 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.,* Comment from FTC Staff to La. State Representative Timothy G. Burns (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 Comment 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/v080018billconlaws.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 Litig., 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 10.

¹² *See, e.g.,* 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>; Comment from FTC Staff to the Dep’t of Veterans Affairs (July 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/160725vastaffcomm1.pdf [hereinafter Comment to the VA] (regarding proposed rule on APRNs); Comment from FTC Staff to W. Va. State Senator Kent Leonhardt (Feb. 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf [hereinafter Comment to the Hon. Kent Leonhardt] (regarding legislation on APRNs); Comment from FTC Staff to the S.C. State Representative Jenny A. Horne (Nov. 2, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-south-carolina-representative-jenny.horne-regarding-house-bill-3508-3078-advanced-practice-registered-nurse-regulations/151103scaprn.pdf (regarding legislation on APRNs); Comment from FTC Staff to the Mo. State Representative Jeanne Kirkton 5 n.11 (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 [hereinafter Comment to the Hon. Jeanne Kirkton] (regarding collaborative practice arrangements between physicians and APRNs); Comment from FTC Staff to Mass. State Representative Kay Khan (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/140123massachusettsnursesletter.pdf (regarding supervisory requirements for nurse practitioners and nurse anesthetists).

¹³ *See, e.g.,* FTC Staff, *Policy Perspectives*, *supra* note 12, at 8 n.32 (noting the policy paper “does not discuss Physician Assistants (PA) scope of practice issues, although PAs and APRNs typically are subject to similar types of rules”); Comment to the Hon. Jeanne Kirkton, *supra* note 12 (FTC staff noted that Missouri “HB633, as approved by the Committee of Professional Registration and Licensing on March 12, 2015, would amend the statute to also include physician assistants and . . . [a]lthough these comments and our March 2014 policy paper refer specifically

to APRNs, we also encourage the legislature to consider our comments, and scrutinize available health and safety evidence, as it evaluates whether and how to impose mandatory collaborative practice arrangements on physician assistants.”). See generally Edward S. Sekscenski et al., *State Practice Environments and the Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse-Midwives*, 331 N. ENGL. J. MED. 1266 (1994) (noting that proposals to increase access to primary care often consider expanding the role of both APRNs and PAs); see also IOM FUTURE OF NURSING REPORT, *supra* note 5, at 88, 97-98.

¹⁴ Medicare and Medicaid Programs; Hospital and Critical Access Hospital Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, 81 Fed. Reg. 39,448, 39,452 (proposed June 16, 2016) (to be codified at 42 C.F.R. pt. 482, 485).

¹⁵ See Nat’l Governors Ass’n, *The Role of Physician Assistants in Health Care Delivery* (2014), <https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1409TheRoleOfPhysicianAssistants.pdf>; Kaiser Comm’n on Medicaid and the Uninsured, Kaiser Family Found., *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants* (Mar. 2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf>.

¹⁶ Am. Acad. of Physician Assistants, *PA Education: Preparation for Excellence* (Dec. 2016), <https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=580>.

¹⁷ Nat’l Governors Ass’n, *supra* note 15 (citing statistics and information from *Primary Care Workforce Facts and Stats No. 3*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY (last updated Oct. 2014), <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/index.html>; Ctrs. for Medicare & Medicaid Servs., *Rural Health Clinic* (Jan. 2016), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctst.pdf>).

¹⁸ Nat’l Governors Ass’n, *supra* note 15, at 2 & nn. 6-7 (again citing statistics and information from AHRQ and CMS); Kaiser Comm’n on Medicaid and the Uninsured, *supra* note 15, at 3 (noting that “NPs and PAs are more likely than primary care physicians to practice in underserved areas and to care for large numbers of minority patients, Medicaid beneficiaries, and uninsured patients” and noting “that these clinicians perform as well as physicians on important clinical outcome measures” for primary care).

¹⁹ *Employment Projections, Fastest Growing Occupations*, BUREAU OF LABOR STATISTICS (last updated Apr., 16, 2016), http://data.bls.gov/cgi-bin/print.pl/emp/ep_table_103.htm.

²⁰ See Sarah Mann, *AAMC Research Confirms Looming Physician Shortage*, ASS’N OF AM. MED. COLLS. (Sept. 27, 2016), <https://news.aamc.org/medical-education/article/aamc-research-physician-shortage/> (AAMC summary based on a 2016 update to a 2015 report by IHS Inc., Life Sciences Division, which AAMC commissioned). The AAMC projects the U.S. “will face a shortage of between 61,700 and 94,700 physicians by 2025, with particularly large shortfalls in certain surgical specialties.” By 2025, projected shortages for primary care physicians range from 14,900 to 35,600 and for surgeons, both general and specialty, from 25,200 to 33,200. The AAMC noted the “primary factors driving demand are population growth and an increase in older Americans,” with the population expected to grow by approximately 8.6 percent and the population of those over 65 years of age expected to increase by 41 percent. Because those over 65 years of age “tend to require more specialized care than younger populations, the shortage in certain specialties . . . will not keep pace with demand.” *Id.* Ass’n of Am. Med. Colls., *Physician Shortages to Worsen Without Increases in Residency Training* (n.d.), https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf; BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES & SERVS. ADMIN., *THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND* 70-72, ex. 51-52 (2008), <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/physiciansupplyissues.pdf> (HRSA’s most recent workforce report on physician supply and demand, projecting increased shortages of both primary care physicians and specialists).

²¹ Ass’n of Am. Med. Colls., *Iowa Physician Workforce Profile* (2015), <https://www.aamc.org/download/447176/data/iowaprofile.pdf>.

²² Physician Assistants, Title IV, IOWA CODE §148C (2016) (includes reference to the 1988 Act establishing the Board of Physician Assistants).

²³ FTC staff have suggested that licensed professionals not be granted the authority to regulate those with whom they compete. *See, e.g.*, Comment to the Hon. Kent Leonhardt, *supra* note 12 (noting that “we strongly suggest that it may be problematic to have independent regulatory boards dominated by medical doctors and doctors of osteopathy serve as regulators of APRN prescribing”); Comment from FTC Staff to the Miss. State Representative Mark Formby (Mar. 22, 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-mark-formby-mississippi-house-representatives-concerning-mississippi/110322mississippipbm.pdf (noting that because pharmacists and pharmacy benefit managers (PBMs) “have a competitive, and at times, adversarial relationship, we are concerned that giving the pharmacy board regulatory power over PBMs may create tensions and conflicts of interest for the pharmacy board,” may increase prescription drug prices and reduce competition within the state, and that “the antitrust laws recognize that there is a real danger that regulatory boards composed of market participants may pursue their own interests rather than those of the state”); *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101 (2015). *See also* BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMIN., *THE PROFESSIONAL PRACTICE ENVIRONMENT OF DENTAL HYGIENISTS IN THE FIFTY STATES AND THE DISTRICT OF COLUMBIA*, 2001, at 80-81 (2004), <http://docplayer.net/13728482-The-professional-practice-environment-of-dental-hygienists-in-the-fifty-states-and-the-district-of-columbia-2001-april-2004.html> (“Dental hygiene is idiosyncratic in that most health professions are self-regulated. Dental hygiene is largely under the purview of dentistry. This is not true for similarly situated medical professionals who are principally self-regulated”). *See generally id.* at 73 (noting “[t]he dental hygiene profession has progressed less quickly than most other health professions. This is largely due to the regulation of the profession of dentistry, a condition that is unusual in health regulation since most other professions are provided with autonomy in governing their constituents.”).

²⁴ IOWA CODE § 148C.3. Section 148C.3(6) also states that the PA Board “shall adopt rules pursuant to this section after consultation with the board of medicine.”

²⁵ IOWA ADMIN. CODE r. 645-326.1, Definitions.

²⁶ r. 645-326.8(1)-(4), Supervision Requirements.

²⁷ r. 645-326.8(4)c.(1), (2).

²⁸ r. 645-327.1(1), Duties.

²⁹ r. 645-327.4, Remote Medical Site. The PA at a remote site must have practiced for at least one year or if less than one year, then the PA must have practiced for at least six months, worked with the supervising physician at the same location for at least three months, and the supervising physician must review patient care at least weekly and sign all patient charts unless there is documentation that the PA directly consulted with the physician for a specific patient. Finally, there is an exception to these stringent requirements if a physician and PA provide a written statement to the PA Board that the PA is qualified to provide the needed medical services and that the medical care will be unavailable at the remote site unless the PA is allowed to practice there. The physician still must make weekly visits and sign all charts unless direct consultation has occurred.

³⁰ S.F. 505, 86th Gen. Assemb. 1st Session, div. XXXI, sec. 113 (Iowa 2015). This appears to be the only provision in Iowa law addressing directly the authority of the BOM to adopt rules concerning PAs, as opposed to disqualification or discipline of MDs related to PA supervision.

³¹ 38 Iowa Admin. Bull. 1415 (Jan. 20, 2016) (BOM’s originally proposed rule, ARC 2372C); 38 Iowa Admin. Bull. 1521 (Feb. 17, 2016) (PA Board’s originally proposed rule, ARC 2417C).

³² 38 Iowa Admin. Bull. 2169 (May 11, 2016) (PA’s proposed amended rule, ARC 2531C); 38 Iowa Admin. Bull. 2190 (May 11, 2016) (BOM’s adopted amended rule, ARC 2532C). It is unclear whether the BOM took into account additional public comments on the amended rule.

³³ See Iowa Board of Medicine website page (stating the rule becomes effective June 15, 2016). *Iowa Code, Rules, Policy*, IOWA BD. OF MED., http://medicalboard.iowa.gov/iowa_code/index.html; Press Release, Iowa Bd. of Med., New Rule Establishes Minimum Standards for Supervision of Physician Assistants (Aug. 18, 2016), <http://medicalboard.iowa.gov/Board%20News/2016/Press%20release%20-%20New%20rule%20establishes%20minimum%20standards%20for%20supervision%20of%20physician%20assistants%20-%20August%2018%202016.pdf> (stating the rule is effective).

³⁴ See Iowa Bd. of Med., Teleconference Meeting Open Minutes (Apr. 15, 2016), <http://medicalboard.iowa.gov/Minutes/2016/PubMin%204-15-16%20Tele.pdf.pdf> (adopting rule and suggesting it would be effective on June 15, 2016, “presuming the Board of Physician Assistants follows suit”).

³⁵ 38 Iowa Admin. Bull. 2162 (May 11, 2016) (Notice of PA Board’s June 3, 2016, Public Hearing on ARC 2531C). The additional board meetings took place on July 20, 2016 and October 19, 2016. The Proposed Rule was suggested at the PA Board meeting on October 19, 2016. The PA Board thereafter drafted the Proposed Rule, and voted to issue this proposal for public comment via a November 15, 2016 teleconference.

³⁶ ARC 2832C, Amended Notice of Intended Action, *supra* note 1.

³⁷ *Id.*

³⁸ *Id.*

³⁹ 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, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 5–6 (1990), https://www.ftc.gov/system/files/documents/reports/costs-benefits-occupational-regulation/cox_foster_-_occupational_licensing.pdf.

⁴⁰ See, e.g., Comment to the Hon. Jeanne Kirkton, *supra* note 12, at 5 n.11(encouraging the Missouri “legislature to consider our comments, and scrutinize available health and safety evidence, as it evaluates whether and how to impose mandatory collaborative practice arrangements on physician assistants”). See also discussion of FTC comments *supra* at notes 12 and 13 and accompanying text.

⁴¹ See, e.g., CHRISTINE E. EIBNER ET AL., RAND, CONTROLLING HEALTH CARE SPENDING IN MASSACHUSETTS: AN ANALYSIS OF OPTIONS 103-104 (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.pdf (suggesting concrete savings that might be associated with expanded APRN and PA scope of practice, due to the lower costs and prices that tend to be associated with services delivered by PAs and APRNs: “between 2010 and 2020, Massachusetts could save \$4.2 to \$8.4 billion through greater reliance on NPs and PAs in the delivery of primary care”); Edward J. Timmons, *Healthcare License Turf Wars: The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on Medicaid Patient Access* 17-18 (Mercatus Working Paper, 2016) <https://www.mercatus.org/system/files/Timmons-Scope-of-Practice-v2.pdf> (finding broader scope of practice for PAs is correlated with less expensive “outpatient care (an 11.8 to 14.4 percent reduction, depending on specification) without negatively affecting access to health care” . . . and that the “results of this paper, combined with findings of other researchers, suggest that broader scope of practice for NPs and PAs has little effect on the quality of care delivered, increases access to health care, and also potentially reduces the costs of providing health care to patients.”); Morris M. Kleiner, et al., *Relaxing Occupation Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 J. L. & ECON. 261, 286 (2016) (study of the costs associated with regulation of APRNs, finding “more rigid regulations increase the price of a well-child visit by 3-16 percent” but found no impact on infant mortality or malpractice claims, suggesting relaxing regulations was unlikely to have adverse medical outcomes).

⁴² See *Barriers to Entrepreneurship: Examining the Anti-Trust Implications of Occupational Licensing: Hearing Before the H. Comm. on Small Bus.*, 113th Cong. 1–3 (2014) (statement of Fed. Trade Comm’n on Competition and the Potential Costs and Benefits of Professional Licensure), <https://www.ftc.gov/public-statements/2014/07/prepared-statement-federal-trade-commission-competition-potential-costs>; Comment to the Hon. Jeanne Kirkton, *supra* note 12, at 5 n.11; Comment to the VA, *supra* note 12, at 2. It is unclear what, if any, health and safety concerns that ARC 2532C, the BOM’s adopted rule, would address.

⁴³ It is our understanding that because the PA Board is proposing a regulation that differs from the one adopted by the BOM, the two Boards must reconcile their differences and adopt parallel rules to comply with the statutory mandate. See discussion of legislative and regulatory background, *supra* at Section II.B.

⁴⁴ IOWA CODE § 148C.3, Licensure (2016); IOWA ADMIN. CODE r. 645-326.8 (148C), Supervision Requirements (2016). See also discussion of legislative and regulatory background, *supra* at Section II.B.

⁴⁵ See FTC Staff, *Policy Perspectives*, *supra* note 12, at 37.

⁴⁶ Current Iowa statutes and regulations appear to permit such flexibility. Importantly, we are not aware of any studies or other evidence that would lead to concerns with how the current supervision requirements are being implemented, or the quality and safety of health care services delivered to patients by supervised PAs.

⁴⁷ Compare ARC 2532C, 653-21.4(1) Definitions with, IOWA ADMIN. CODE r. 645-326.1. Definitions.

⁴⁸ ARC 2532C, 653-21.4 (2), Minimum Standards, 653-21.4(2)b. Face-To-Face Meetings; and 653-21.4(2)e. Chart Reviews.

⁴⁹ Compare ARC 2532C, 653-21.4, Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician with, IOWA ADMIN. CODE r. 645-326.8 (specifying supervision requirements); ARC 2532C, 653-21.4(2)a. Review of Requirements with, IOWA ADMIN. CODE r. 645-326.8(4) (PA and supervising physician are each responsible for knowing and complying with the supervision provisions of these rules); ARC 2532C, 653-21.4(2)c. Assessment of Education, Training, Skills, And Experience with, IOWA ADMIN. CODE r. 645-327.1 Duties and 327.1(1) (the supervising physician must have sufficient training or experience with the delegated tasks and must determine the PA’s proficiency and competence); ARC 2532C, 653-21.4(2) d. Communication, g. Timely Consultation, and h. Alternate Supervision, with, IOWA ADMIN. CODE r. 645-326.8(4), 645-326.8(4)a. and b. (PA cannot practice if supervision is unavailable and supervisor and PA must review patient care on an ongoing basis as indicated by the clinical condition of the patient, which can occur in person, by telephone or by other telecommunicative means); ARC 2532C, 653-21.4(3), Amendment with, IOWA CODE § 148C.3.1. (specifying only that the PA “board shall adopt rules to govern the licensure of physician assistants”); and ARC 2532C, 653-21.4(4) Joint Waiver or Variance with, IOWA ADMIN. CODE r. 645-327.4(1)c. and 327.4(2) (specifying when the PA Board may permit variances with respect to care provided at a remote site). *But cf.* ARC 2532C, 653-21.4(2)f., Delegated Services, which expressly incorporates by reference one of the PA Board’s existing regulations (stating in part: “The medical services and medical tasks delegated to and provided by the physician assistant shall be in compliance with 645—subrule 327.1(1).”).

⁵⁰ See, e.g., Comments from Faculty of the Dept. of Physician Assistant Studies & Services, Carver College of Medicine, University of Iowa to the Iowa Bd. of Physician Assistants (Jan. 19, 2016; April 20, 2016) (explaining that University of Iowa Health Care (“UIHC”) has “a pre-existing chart review QI in place in each department for all providers (physicians, PA’s, ARNP’s, etc.) . . . but that system would not meet the chart review requirements of the proposed rule, so supervising physicians would have to specifically add more chart review time to go over PA charts”). See also public comments referenced, *infra*, at note 54; Comment from Libby Coyte, PA, former chair, Iowa Bd. of Physician Assistants and former member, Iowa Bd. of Med. to Iowa Bd. of Physician Assistants (Mar. 8, 2016) (noting “rules 327.8(b-J) are restatements of what is already in the PA rules but are more restrictive and vary enough to be confusing to licensees”); Nat’l Governors Ass’n, *supra* note 15, at 11 (noting state policy should consider whether “[u]nclear statutes or regulations may inadvertently limit PAs’ ability to participate in innovations” and that “[o]verly strict statutes or regulations may interfere with physicians’ ability to delegate tasks to PAs”).

⁵¹ ARC 2532C states:

At least one supervising physician shall meet face-to-face with each physician assistant a minimum of twice annually. If the physician assistant is practicing at a remote site, both meetings shall be at the remote site. Each party shall ensure that the face-to-face meetings are documented. The meetings are for the purpose of discussing topics deemed appropriate by the physician or the physician assistant, including supervision requirements, assessment of education, training, skills, and experience, review of delegated services, and medical services provided by the physician assistant.

⁵² See, e.g., American Academy of PAs, *Iowa PA Practice Profile* (2015), <https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=1610> (approximately 64% of PAs are employed by a physician group or solo practice, 26.4% practice in hospital settings, and 41.1% practice in rural areas); Comments from Paul A. James, MD, Chair, Dept. of Family Medicine, Carver College of Medicine, University of Iowa to the Iowa Bd. of Medicine (Mar. 9, 2016) (stating the proposed minimum standards are not necessary and noting that at the Family Medicine Clinic at the University of Iowa Hospitals and Clinics there are over 20 supervising physicians for two highly trained PAs, who “are under the direct observation of physicians every day, seeking guidance or reassurance in the course of caring for patients”).

⁵³ See, e.g., Comment from American Academy of PAs to Bd. of Physician Assistants (June 2, 2016) (public comment on ARC 2531C) (noting economic impact analysis conducted jointly with the Iowa Society of Physician Assistants estimates a \$2.9 million burden on Iowa’s healthcare system and a loss of approximately 44,500 patient encounters).

⁵⁴ See, e.g., Comments from Faculty of the Dept. of Physician Assistant Studies & Services, *supra* note 50 (UIHC estimated that the originally proposed rules would have cost UIHC \$502,200 for the 75 PAs it employs; its updated cost estimate to implement ARC 2532C projected \$315,000 in additional costs per year); Iowa Bd. of Physician Assistants, *Jobs Impact Analysis: ARC 2417C* (Mar. 3, 2016) (although the Job Impact Analysis conclusions were based on the original rule, there were 84 comments from PAs, physicians, and hospitals in response to the survey, many of which raised concerns about what perceived need was being addressed by the proposed rules and how or whether existing review systems would meet the requirements of the proposed rules. For example, one hospital (comment No. 76) noted “Because our mid-levels work side-by-side with our physicians their work is being evaluated on an on-going basis. Additional formal chart review beyond the chart review we already provide would essentially [be] an exercise in pushing additional paper around in order to meet requirement and would not improve quality.”). ARC 2532C also does not appear to contemplate any flexibility to the requirement for face-to-face meetings based on the PA’s experience and training, how long the PA and physician have worked together, diverse circumstances and clinical needs, new models of consultation and supervision, or new technologies or institutional resources.

⁵⁵ IOWA ADMIN. CODE r. 645-327.4(2).

⁵⁶ Press Release, Iowa Bd. of Med., *supra* note 33.

⁵⁷ See discussion *infra* at notes 58-63 and accompanying text (discussing the costs associated with such face-to-face meeting requirements, the fact that many states and CMS do not have such requirements, and the potential use of telehealth or other innovations in health care delivery that might be stymied by such requirements). Increasingly, telehealth is being used successfully to facilitate supervision and collaboration among health care providers, as well as for the direct provision of health care services. See, e.g., Comment from FTC Staff to the Delaware Bd. of Occupational Therapy Practice (Aug. 3, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-occupational-therapy-concerning-its-proposed-telehealth-regulation/v160014_delaware_ot_proposed_advocacy.pdf (noting proposed telehealth regulation would likely enhance competition and improve access to occupational therapy services by “not imposing rigid and unwarranted in-person care and supervision requirements”); Brian J. Miller, et al., Commentary, *Telemedicine and the Sharing Economy: The “Uber” for Healthcare*, 22 AM. J. MANAGED CARE, Dec. 2016, at 294, 295 (noting that telehealth platforms can “expand access to general medical services by reaching out to consumers in underserved areas and providing access to highly specialized consult services . . . [and] that physicians have successfully practiced telemedicine for over 100 years by using the telephone to conduct physician-to-physician consults, diagnose and treat patients, prescribe medications, and order diagnostic tests”).

⁵⁸ Am. Acad. of Physician Assistants, *Six Key Elements of a Modern PA Practice Act* (Oct. 26, 2016), <https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=799> (chart of status for all states and the District of Columbia). South Dakota became the 28th state (29th including DC) when its Board of Medical and Osteopathic Examiners (“SDBOME”) repealed its remote site visit requirement in September 2016. S.D. Bd. of Med. & Osteopathic Examiners, *Notice of New Rules* (Sept. 2016), <http://www.sdbmoe.gov/sites/default/files/Notice%20of%20New%20Rules.pdf> (SDBOME explained changes to its regulations concerning PAs, noting they removed the requirement that a supervising physician must visit each PA practice location every 90 days; eliminated the required in-person meeting as a condition of the supervision agreement; and allow the Physician/PA team to determine the best supervision arrangement).

⁵⁹ Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II, Final Rule, 79 Fed. Reg. 27,106, 27,131 (May 12, 2014) (to be codified at 42 CFR pt. 413, 416, 440, 442, 482, 483, 485, 486, 491, 493), <https://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf> [hereinafter CMS 2014 Burden Reduction].

⁶⁰ CMS 2014 Burden Reduction, *supra* note 59, at 27,131.

⁶¹ *Id.* at 27,150 (CMS estimated a total annual savings of \$75,639,190 million by eliminating face-to-face visits and specified chart reviews for CAHs, RHCs, and FQHCs).

⁶² See, e.g., *Id.* at 27,131 & 27,149-50 (discussing both out-of-pocket costs and loss of patient encounters resulting from inflexible face-to-face meeting requirements); Comment from Nancy Bucklew, President, Iowa Ass’n of Rural Health Clinics to Bd. of Physician Assistants (Mar. 9, 2016) (“requiring face to face meetings prevents RHCs from fully utilizing our PAs for tele-emergency and tele-psychiatry to the detriment of our patients”).

⁶³ See, e.g., Comment from FTC Staff to the Delaware Board of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers (Nov. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-speech/language-pathologists-audiologists-hearing-aid-dispensers-regarding-its-proposed-revisions-its/161130_ftc_dealers_final_.pdf (commenting positively on the board’s proposal “to remove existing restrictions on service by telecommunication and allow licensees to determine whether telepractice is an appropriate level of care, . . . which could enhance consumer choice by providing an alternative to in-person care, potentially reducing travel expenditures, increasing access to care, and increasing competition, as well as suggesting additional procompetitive steps the board might consider); Comment from FTC Staff to the Del. Bd. of Dietetics/Nutrition (Aug. 16, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-dietetics/nutrition-regarding-its-proposed-telehealth-regulation/staff_comment_delaware_diet_telehealth_signed.pdf (same, but noting the proposed rules would limit flexibility by requiring all initial evaluations to be performed face-to-face and not through telehealth); Comment from FTC Staff to Steve Thompson, Representative, Alaska State Legislature (Mar. 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alaska-state-legislature-regarding-telehealth-provisions-senate-bill-74-which/160328alaskatelehealthcomment.pdf (noting telehealth provisions that eliminate the in-state requirement for Alaska-licensed physicians appear to be a procompetitive improvement in the law and likely would expand the supply of telehealth providers, promote competition, and increase access to safe and cost-effective care, as well as reduce transportation costs for Alaska patients and providers).

⁶⁴ IOWA ADMIN. CODE r. 645-327.4 b(4).

⁶⁵ Am. Acad. of Physician Assistants, *supra* note 58.

⁶⁶ CMS 2014 Burden Reduction, *supra* note 59, at 27,131. See also *id.* at 27,133 (CMS noted if “the applicable State law does not require a record review or cosignature, or both, by a collaborating physician, then CMS does not require such periodic record review” and that there is no CMS “regulatory requirement for the review of records to be performed onsite and in person”).

⁶⁷ See discussion *supra* at notes 50 and 54 and accompanying text.

⁶⁸ See UIHC Comment and other public comments discussed *supra* at notes 53 and 54 and accompanying text.