Ohio State Medical Association

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Opponent Testimony to the Ohio House Medicaid Committee
Ohio State Medical Association
HB 508 – Advanced Practice Registered Nurses
Presented by Monica Hueckel, VP, Advocacy

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Chair Gross, Vice Chair Barhorst, Ranking Member Baker, and members of the House Medicaid Committee, my name is Monica Hueckel and I am here on behalf of the Ohio State Medical Association (OSMA), the state's oldest and largest professional organization representing Ohio physicians, medical residents, and medical students. Thank you for the opportunity to testify and express our concerns today regarding House Bill 508.

HB 508 and the History of this Issue

OSMA is committed to evaluating scope of practice proposals through collaborative discussion between all involved parties, with a common goal of continuing to promote delivery of high quality patient care in Ohio. Over the years, we have worked together and made several modernizations to the scope of practice of advanced practice registered nurses (APRNs), while continuing to express concerns with full independent practice authority and the negative impact it would have on patients.

As recently as last general assembly, OSMA and other interested parties all worked together with the sponsor of Senate Bill 196, which made dozens of changes to the scope of practice of APRNs. Proponents of SB 196 last year touted its provisions as changes which would help improve access to care in Ohio. SB 196 passed and went into effect this spring. There has been no time to actually assess the impact SB 196 has had on Ohio. Despite this, the legislature is already being asked to consider even more changes in the name of "increased access to care", including full expansion to independent practice authority, without strong evidence of necessity for more changes or even fully reflecting upon the changes already implemented.

The main provisions in HB 508 have also been debated in previous legislative sessions. Each time we have discussed the issue, OSMA has consistently offered solutions to the main arguments the proponents have made for the bill: Physicians charge for collaboration, collaboration does not mean anything and it is impossible to find a collaborator. In my testimony I will again, offer solutions to these common arguments, as I have for the past 10 years.

Standard Care Arrangement (SCA)

Proponents of HB 508 have repeatedly minimized the standard care arrangement and claimed that it is "just a piece of paper." The SCA is not just a piece of paper. While it is not required to be approved by either the Board of Nursing or the Medical Board, nor is it even filed with either of the boards, it is an important agreement established between the APRN and physician collaborator. It is purposely designed to be flexible and customizable, allowing for the physician and APRN to determine the nature and function of their collaborative relationship. Among the parameters that each physician and APRN

set for how their collaboration will work in day-to-day patient care, several specific components are required:

- Criteria for referral of a patient to the collaborating physician;
- The process by which to consult with the collaborating physician;
- A plan for coverage in instances of emergency or planned absences of either the APRN or physician;
- The procedure for review of the care outcomes for the patients seen by the APRN;
- The process for resolution of disagreements,; and,
- The policy for the care of infants up to age one.

An APRN has extensive freedoms in a standard care arrangement that include working to diagnose specific conditions, prescribing authority, the ability to order tests, and more. Through the SCA, a physician serves as a safety buffer, providing insight based on a vast difference in clinical training hours and breadth of education. This helps to keep the patient safe and avoid some unnecessary health care costs incurred by erroneous testing orders or misdiagnosis, for example.

OSMA has also heard the accusations that collaborators at times do not even live in Ohio and that they charge APRNs to collaborate. I will again offer the solutions I have in the past: Require collaborators to physically live in Ohio, and prohibit a charge for signing a collaboration agreement. I offered these solutions first in 2015, again in 2019 and now once again in 2025. If this is truly a problem, why have OSMA's previous attempts to solve this issue been turned down?

Access to Care

Proponents of this issue often cite increased access to care as a reason for terminating the standard care arrangement. While access to care for Ohioans remains high priority for OSMA, we do not believe that HB 508 would effectively or safely do so in a meaningful way.

Ohio is fortunate that our Ohio Board of Nursing publishes data on their licenses every other year. The most recent report highlights very important data on how many APRNs we have licensed, what the most common practice settings are and how APRNs are specializing. Of the 28,201 APRNs that responded:

- Only 4,367 APRNs answered that their specialty is primary care.
- 482 APRNs reported that they are working in their own self-owned practice. When this issue was debated in 2015, roughly 200 APRNs owned their own practice, so this represents a steady increase over the years for APRNs in this practice setting; however, this highlights that the vast majority of APRNs are working in practice settings directly employed by physicians or working alongside physicians collaboratively to care for patients.
- According to the Kaiser Family Foundation, Ohio is a top ten state for physicians, ranking at #7 in the country with 42,508 active physicians, 20,590 of which are primary care physicians. Ohio's current law sets a ratio of allowing up to five APRNs to collaborate with one physician, at any time, meaning that theoretically, Ohio APRNs have over 212,000 opportunities for collaboration with a physician in Ohio, a number which more than accounts for the active APRNs in Ohio finding collaborators, even if not every physician wishes to enter into an SCA with APRNs.
- One of the hospitals testifying as proponents of this legislation indicated that they support HB 508 because they currently operate with a ratio of one APRN for every one physician. The witness cited a projection that by 2028, they will have to break this ratio; however, as indicated, Ohio law currently allows a ratio for collaborations that means every physician can collaborate

with up to five APRNs at a time, so the one-to-one ratio mentioned by the witness is not a problem that exists in statute and needs to be addressed.

- Studies conducted by the American Medical Association (AMA) show that midlevel providers like APRNs obtaining full unsupervised practice authority does not provide incentive to locate to rural or underserved areas. APRNs are still largely concentrated in highly-populated, urban areas in the states which allow independent practice authority. There is also no restriction in current Ohio law preventing APRNs to locate to rural Ohio. If they are not practicing there, it is because they are choosing not to.
- Arizona appears to be the only APRN independent practice state that has tracked rural practice location data. In a five-year span, out of nearly 7,000 new APRNs in the state, they only saw 5 of those APRNs move to a deeply rural area to practice and about 400 went to larger rural areas. The remaining thousands of those APRNs flocked to urban and suburban practice settings.

Overall, we do not believe the data supports the claim that Ohio APRNs are struggling to find collaborating physicians with whom to enter into standard care arrangements, nor does it support that HB 508 would result in a significant increase in primary care access or rural access to care.

Patient Care and Safety

At the heart of this issue, though, are Ohio's patients and *patient* care. We want to stress that our main focus is what is best for patients. Complete elimination of physician oversight on patient care delivered by APRNs could have serious implications on patient safety and health outcomes. The current model of physician-led, team-based care works by allowing a balance and cooperation amongst all involved in patient diagnosis and treatment. We believe that all patients, regardless of their ZIP code, deserve the highest quality care delivered under the team-based, physician led approach.

OSMA is thankful to members of the committee for your attention to our comments and concerns on this legislation, and appreciates the opportunity to be a meaningful contributor to the legislative process. I would be happy to answer any questions the committee may have.