January 7, 2021

Robert Wilkie
Secretary
Department of Veterans Affairs
810 Vermont Ave. NW, Room 1068
Washington, DC 20420

Re: RIN 2900–AQ94—Authority of VA Professionals to Practice Health Care

Dear Secretary Wilkie,

The undersigned physician organizations representing national specialty and state medical societies are writing in opposition to the Department of Veterans Affairs' Interim Final Rule, entitled "Authority of VA Professionals to Practice Health Care," which permits virtually all VHA-employed non-physician providers (NPPs) to practice without the clinical supervision of physicians and without regard to state scope of practice law.

NPPs are an integral part of physician-led health care teams. However, NPPs cannot substitute for physicians especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. Nowhere is this more important than at the Department of Veterans Affairs (VA), which delivers multifaceted medical care to veterans, including those with traumatic brain injuries and other serious medical and mental health issues. As such, our nation's veterans deserve high quality health care that is overseen by physicians. For the reasons below, **the undersigned organizations strongly oppose the Interim Final Rule (IFR) and urge the VA to rescind the IFR and consider policy alternatives that prioritize physician led team-based care.**

The IFR violates the Administrative Procedure Act.

The IFR represents unlawful rulemaking because no good cause exists for the VA's failure to comply with the notice and comment requirements. The Administrative Procedure Act (APA) authorizes an agency to issue a rule without prior notice and opportunity for public comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest."[1] One of the reasons that the VA provides for bypassing the protections and procedures of the APA is "to facilitate the implementation of the new EHR system immediately."[2] However, the VA has been working on creating and implementing their electronic health record (EHR) system since 2017.[3] It is unclear, why now, the VA needs to expedite the process and implement this program in violation of the APA. The VA also states that COVID-19 has necessitated the quick shifting of health care professionals across the country. However, since the public health emergency has begun the VHA has hired over 12,000 new employees to supplement surge capacity.[4] Moreover, the VA did not explain why these expanded scope provisions would be needed permanently rather than just during the public health emergency (PHE), with a built-in sunset clause, as is the case for most of the other state and federal based PHE plans. As such, the VA did not possess good cause when it bypassed the APA and acted arbitrarily and capriciously by failing to adequately consider the rights of the states, the training of its personnel, and the long-term safety of our nations' veterans.

[1] 5 U.S.C. §§ 553(b),706(2).
[2] https://www.federalregister.gov/d/2020-24817/p-65.
[3] https://www.ehrm.va.gov/resources/factsheet.
[4] https://www.va.gov/HEALTH/docs/VHA_COVID-19_Response_Report.pdf.

The IFR does not meet the standards set out in Executive Order 13132 and therefore, inappropriately preempts state scope of practice laws.

The IFR attempts to preempt state law by asserting that state and local scope of practice laws relating to NPPs that are employed by the VA "will have no force or effect," and that state and local governments "have no legal authority to enforce them." However, the requirements to preempt state law, set forth in Executive Order 13132, have not been met.[5] The VA did not "provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings."[6] This can be seen by the fact that the VA did not provide any time for comments and instead published the IFR on the same day the rule took effect, which was not "deferential to the States" and gave no opportunity for the States, state medical boards, specialty societies, or any stakeholders, to meaningfully participate in the proceedings.[7] As such, the VA did not follow the guidelines set out in Executive Over 13132 and "act only with the greatest caution."[8] Moreover, since health care professionals employed by the VA must still have a state medical license, this IFR will cause state medical boards to certify individuals under the false assumption that they will be practicing medicine according to state scope of practice law. This will likely lead to NPPs performing procedures for which they are not trained to perform and for which there could be serious unintended consequences for the patient, provider, and agency.

The IFR does not adequately account for the differences in education and training that exist between physicians and NPPs and thus, does not sufficiently address the lower standard of care that will ultimately be provided to veterans.

There are stark differences between the education and training requirements for physicians and NPPs. Medical students spend four years learning both the physiologic and clinical components of evidence-based medicine before undertaking an additional three to seven years of residency training to further develop and refine their ability to safely evaluate, diagnose, treat, and manage the health care needs of patients. By gradually reducing teaching physician oversight, residents are able to develop their skills with progressively increasing autonomy, thus preparing these physicians for the independent practice of medicine.

No other healthcare professionals come close to the level of training required of physicians. With more than 10,000 hours of clinical experience, physicians are uniquely qualified to lead health care teams. By contrast, nurse practitioners (NPs) must complete only two to three years of graduate level education and 500-720 hours of clinical training. Physician Assistant (PA) programs are two years in length and require 2,000 hours of clinical care.[9] But it is more than just the vast difference in hours of education and training, it is also the difference in rigor and standardization between medical school and residency and nurse practitioner programs. NPs and PAs are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. As such, the VA removing scope of practice safeguards will allow for NPPs that have not been adequately trained to perform procedures that are outside the scope of their licensure, ultimately leading to a lower standard of care for veterans.

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[5] https://www.govinfo.gov/content/pkg/FR-1999-08-10/pdf/99-20729.pdf.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] https://www.ama-assn.org/system/files?file=corp/media-browser/premium/arc/ama-issue-brief-independent-nursing-practice.pdf.

The IFR does not take into account the importance of state licensing boards and the inadequate oversight of NPPs within the VA.

State licensing boards play an important role in ensuring that medical care is properly administered and that providers are disciplined when malpractice is committed. However, with the VA removing state scope of practice laws and regulations, it will be extremely difficult for state boards to adequately oversee NPPs. Moreover, unlike physicians that are supposed to have their licenses reviewed every two years, registered nurses and other NPPs within the VA are appointed for an indefinite time, meaning that their credentials are reviewed before they are hired and may never be reviewed again.[10] As such, according to multiple Government Accountability Office (GAO) audits, the VA is doing an inadequate job of supervising and disciplining its NPPs. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA providers.[11] The issues reported range from providers lacking appropriate qualifications, to poor performance and provider misconduct.[12] Unfortunately, the VA has been deficient in putting an end to this subpar care in part, due to the fact that VA medical center officials lack the information they need to make decisions about providers' privileges due to poor VA reporting. Owing to the VA's inadequate oversight, VA medical center officials are not reviewing all of the providers for whom clinical care concerns were raised, and the VA is not taking appropriate adverse privileging actions.[13] This includes certain VA medical centers not reporting providers to the National Practitioner Data Bank (NPDB) or to state licensing boards as is required by law.[14]

Since the VA already has numerous problems with quality of care, the VA should not expand its scope of practice parameters and allow NPPs to perform procedures for which they are not properly licensed or trained. By implementing this IFR, the VA is making it difficult for state boards to oversee the practitioners that they license and will likely make it tougher to discipline NPPs that inadequately care for patients due to a lack of clarity about these practitioners' scope of practice. Since it has been shown that the VA is unable to adequately oversee healthcare providers, it is vital to rescind the IFR and ensure that state licensing boards can adequately supervise their NPPs to ensure the highest quality of care for veterans.[15]

The VA should not be granted uniform practitioner privileging as a result of their inadequate EHR system.

In the IFR, the VA argues that NPPs need to practice independently due to the newly created EHR which purportedly requires uniform privileging irrespective of where care is delivered. "An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users."[16] EHRs also provide privileging options, meaning that they will provide only a certain amount of access and authority to providers depending on their licensure. Despite multiple EHR systems across the U.S. allowing for differing levels of privileging, the VA is arguing that it must develop uniform standards of practice because the new EHR system, which it developed in conjunction with the Department of Defense over the course of years, requires all practitioners with the same license to have the same practice privileges. However, the VA should not be rewarded with a universalized privileging system for building a $10 billion EHR system that is subpar and does not meet state scope of practice law.[17] Moreover, if there must be uniform

[10] https://www.gao.gov/assets/700/697173.pdf.
[11] https://www.gao.gov/assets/710/702090.pdf.
[12] https://www.gao.gov/assets/710/702090.pdf.
[13] https://www.gao.gov/assets/710/702090.pdf.
[14] https://www.gao.gov/assets/710/702090.pdf.
[15] https://www.gao.gov/assets/700/697173.pdf.
[16] https://www.healthit.gov/faq/what-electronic-health-record-ehr.
[17] https://www.gao.gov/assets/710/700478.pdf.

privileging in the VA then, instead of setting practice privileges to align with the least restrictive scope provisions, the VA should ensure that veterans are provided with the best care and adhere to the most conservative state scope requirements.

Our nation's veterans should be provided with physician led healthcare teams that consider important scope of practice limitations and make the most of the respective education and training of physicians and NPPs. To that end, **the undersigned urge the VA to provide our veterans with the highest possible quality of care and rescind the IFR.**

Sincerely,

American Medical Association
Academy of Consultation-Liaison Psychiatry
Academy of Otolaryngology- Head and Neck Surgery
American Academy of Allergy, Asthma & Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgeons
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American Gastroenterological Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Laser Medicine and Surgery
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Dermatopathology
American Society of Echocardiography
American Society of Interventional Pain Physicians

American Society of Neuroradiology
American Society of Plastic Surgeons
American Urological Association
American Vein & Lymphatic Society
American Venous Forum
Association of University Radiologists
College of Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
International Society for the Advancement of Spine Surgery
National Association of Medical Examiners
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society of Interventional Radiology
Society of Nuclear Medicine and Molecular Imaging
Spine Intervention Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York

North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society