PO BOX 1163

Columbia, SC 29202

September 10, 2025

The Honorable Senate Medical Affairs Committee
Senator Medical Affairs Committee
Senator Danny Verdin, Chairman
Senator Davis, Chairman of Subcommittee
SC Statehouse Grounds
Gressette Building
Columbia, SC 29201

Good afternoon Senators. Thank you all for allowing me to speak. I know that this has been a long day for you all. My name is Dr Stephanie Burgess, PhD, APRN, FAAN, FAANP. I am speaking on behalf of the Coalition for Access to Health Care, which represents over 7000 NPs in SC. I am a family nurse practitioner, retired Associate Dean/Acting Dean USC, and retired Director of the USC Graduate Doctoral and NP program. I am still practicing as an NP, now for over 30 years.

FYI: The Gallup just released its rankings based on the most trusted professions among our population. GUESS WHAT..... FOR 23 years in a row, Nurses are ranked as the most trusted profession among all professions (news.gallup.com).

Today, we are speaking in support of Senate Bill 45 and opposing Senate Bill 669.

Here's why.

1. **Choice**
   We believe patients should have the choice (right) to select their primary care provider. We heartily support team-based care, but that team is comprised of professionals that the patient chooses to care for them. It is not necessarily a physician-led team but rather it is left up to the patient and family to select their primary care team. In other words, let the market drive that show.

Clearly, the physician-led team is appropriate in a specialty acute care setting such as the emergency room (ER) or the operating room or a specialty care practice such as oncology, nephrology, or neurosurgery. We support that, but we are talking about primary care settings: Family practice, pediatrics, gerontology, psychiatric mental health, and primary care women's health.

Just a few facts:

In 2024-2025, Medicaid expenditures thus far for individuals with Alzheimer's in South Carolina totals $887 million. https://aging.sc.gov/sites/default/files/documents/ARCC/FY24%20ARCC%20Report.pdf

There are only 70 practicing geriatricians statewide. To meet the projected demand by 2030, that number must increase by 214%. https://aging.sc.gov/sites/default/files/documents/ARCC/FY24%20ARCC%20Report.pdf

There are severe physician shortages in SC, particularly in primary care, psychiatric care, pediatrics, and women's health. South Carolina Health Professions Databook (2024). AHEC Data Workforce 2022 and 2024. https://www.scahec.net/scohw/data/reports/139-SCOHW-Data-Book-2024.pdf).

Cicero Institute, 2025. SC Physician Shortage Facts, 2024.

- 22 Counties with fewer than 3 active family practice physicians per 10, 000 population.
- 15 Counties with ZERO (none) OBGYNS per 10,000 women.
- 10 Counties with ZERO (none) active pediatric physicians.
- 17 Counties with ZERO (none) active general psychiatric physicians.
- SC is projected to have a shortage of 3,230 physicians by 2030. Primary care is projected to be short 815 physician providers by 2030.
- There is a negative 14% growth of physicians in rural areas.
- There is a positive 83% growth of NPs in rural areas.

2. Cost savings

SC Ranks 18th in the nation for Emergency Room costs, a number one ranking indicates the costliest ER visits. The average ER visit in SC starts at $1100-$1700, depending on labs, procedures or interventions, and medications. That is a very

expensive way to receive primary care. The top 10 reasons Medicaid beneficiaries sought the ER in 2027 were for primary care complaints costing the state millions of dollars. Keeping patients out of the ER for primary care saves businesses and taxpayers millions of dollars per year. https://www.cbsnews.com/pictures/emergency-room-visit-cost-most-expensive-states/35/. SC DHHS Medicaid, personal communication Dr. M. Burton and Dr. T. Platt, 2015-2016.

Since 2018, when we did our last scope of practice bill to remove barriers to care, access to care improved from 41 (50 is the worst) to 37. AHEC data show that NPs are maintaining primary care in this state, but we can do more to reduce costs and increase access. South Carolina Health Professions Databook (2024). AHEC Data Workforce 2022 and 2024. https://www.scahec.net/scohw/data/reports/139-SCOHW-Data-Book-2024.pdf

I want to share my story. My primary care practice was in an impoverished area near Providence Hospital, and in conjunction with 4 other NPs, we served over 70% Medicaid and Medicare in Richland County, and many of our patients came from all counties in the state, including those in foster care, homeless shelters, SC Department of Mental Health, SC Department of Developmental Disabilities, SC Department of Juvenile Justice, and the HIV Network. Over the course of 24 years, we saved the state millions of dollars per year serving an average of 3000 patients per year. Cost was contained by keeping patients out of the ER. In fact, a Medicaid Payer Program recognized our practice in 2016 as one of the top three primary care practices in SC saving taxpayer millions of dollars. How did we do this? By keeping patients out of the ER and improving patient outcomes for chronic health problems: reducing obesity, reducing AIC for our diabetics, and lowering lipids.

In terms of reimbursement, NPs receive 80-85% of the physician charge for the same service and office visit under CMS and most payer systems like BCBS. Unlike physicians, NPs and CNMs are forbidden to bill the patient for the extra monies that those payers do not reimburse. However, physicians are allowed to bill the patient or the secondary insurance plan for costs not covered by Medicare. That is a CMS rule (Centers for Medicaid and Medicare). So, it makes sense for the patient to see us in primary care; the payers save money, and the state saves money.

3. **Control**

As said earlier, there are NP practices in the state saving SC millions of dollars per year with improved patient chronic disease outcomes, increasing access to care, and keeping patients out of the ER for primary care.

But the reality is that on Monday when I have my collaborating physician and agreement in place, and on Tuesday the MD suddenly passes, I must close my practice until I can find another physician to sign a practice agreement. This reality has happened to me 6 times. My collaborating physicians passed, re-located out of state, or resigned/retired. All six times, I had to suspend my practice, and the unintended consequence left my patients without a provider except the ER. This past year, my collaborating physician at one of my practice sites resigned; this practice site is through a contract I have with a facility to provide services in an outpatient clinic. As a result, it took me two months to find another physician collaborator, and meanwhile my patients were left unserved, had delays in treatment, or sought the ER for care.

Bottom line without a physician written practice agreement, I can't see patients, call in prescriptions, counsel patients, order tests, review labs, etc. This forces my patients to seek the ER for care or have delays in care, ramping up the cost of health care with unintended consequences such as acute unstable health problems. Furthermore, when suspending a practice to find a physician collaborator, office operating expenses and payroll must still be met, with no income to meet expenses. Running a small business is difficult, even in the best of circumstances.

Think about it this way. You are running a dairy farm, or law practice, or a feed/garden center. Either way you are running a business. But to establish your business, you must have a collaborative agreement with a judge, county administrator for agriculture, or the small business association manager. On Monday Sept 15, 2025 your collaborative agreement is no longer valid because your collaborating judge, administrator, or small business manager has died, moved away, or quit. Now, you must suspend your business, and your clients or customers are left holding the bag. You can't order supplies, file motions, conduct depositions, process feeding programs for the cows, and can't sell your dairy products or feed/garden supplies, etc.

The current law requires that we have a collaborating physician to practice, otherwise, we have to suspend our practice or close it permanently (LLR, Board of

Nursing, SC. Nurse Practice Act. 92024).
https://www.scstatehouse.gov/code/t40c033.php).

What about paying our physician collaborators? Physicians were paid $500 per month at one of my practice contracts. Did they come on site? NO. Did they conduct chart audits? NO. They were available for consultation and advice by telecommunications per the law requirements. For your information, there is a site where an NP can pay a fee to obtain a collaborating physician signature on the practice agreement, to the tune of $500.00 for a match fee and a monthly fee ranging from $500 to $1000 per month. (https://collaboratingdocs.com/?utm_source=google&utm_medium=cpc&utm_campaign=19426370564&utm_term=md%20collaborate&utm_content=667733548978&gad_source=1&gad_campaignid=19426370564&gbraid=0AAAABqkFh2WlMLk-M_cSk8arCc2rDOfm&gclid=CjwKCAjw_fnFBhB0EiwAH_MfZjt1kaEFrAYbynUdiHOcVKrWaFhqBxO7XihYs1LdqKJO4E4KSaTgUBoC-z0QAvD_BwE).

The AMA scope creep document published in January 2025 cites 5 priorities for physicians; one is to fight scope creep. NONE OF THE PRIORITIES ARE ABOUT PATIENT CARE or ACCESS TO CARE. The priorities are: Reform Medicare Payment, Fixing Prior Authorization, Fighting Scope Creep, Reducing Physician Burnout, and Supporting Telehealth. They couch fighting scope of practice bills on the guise of "ensuring safety and quality of care." (AMA Scope Creep, 2025).

As you listen to testimony from SCMA physicians, you hear that APRNs are unsafe, NPs overprescribe antibiotics, make inappropriate referrals, or order unnecessary diagnostic testing. We don't refute those studies because I am sure there are instances where that has occurred.

However, there are decades of research to show that NPs and CNMs are safe, order appropriate tests, prescribe appropriately, yield better outcomes in chronic disease management, and for CNMs lowering C-section rates. Those studies and sources are in a binder that we have prepared for you all to assist you in addressing your concerns or questions.

On the contrary, there are multiple studies from NIH, Harvard Medical School, Academy of Family Practice, and other research entities that show: (https://pmc.ncbi.nlm.nih.gov/articles/PMC7079390/ (2020); https://www.nature.com/articles/d41586-023-02299-w (2023);

https://academic.oup.com/humrep/article/33/5/770/4956366#google_vignette (2018); https://www.sciencedirect.com/science/article/pii/S2451865418300693 (2018); https://www.aafp.org/pubs/afp/issues/2021/0615/p757.html (2021); https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/; https://www.justice.gov/archives/opa/pr/doctor-sentenced-54m-medicare-fraud-scheme (2024); https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf (2023).

- Physicians committing Medicaid and Medicare Fraud. Just last year, a physician was sentenced to 10 years in prison for committing Medicare Fraud to the tune of $54 million dollars costing taxpayers millions of dollars and putting the health and welfare of the Medicare Beneficiaries at risk.
- Falsifying or fabricating results in Clinical Drug Trials.
- Failing to adhere to NIH study protocols for drug or device clinical trials.
- Committing bias when caring for disparate patients, resulting in delays in treatment and poor outcomes for patients.

We are not here to disparage the physicians or mudsling. I work with great physicians; they provide great care and are very respectful to staff, patients, and other providers. And yes, they call me Dr. Burgess.

Along those lines, I do want to point out that the Lewis Blackman Bill requires all health professionals to identify themselves by name, credentials, and title. (https://www.scstatehouse.gov/sess116_2005-2006/bills/3832.htm).

Moreover, the Board of Nursing has rules in place to discipline APRNs who exceed their scope or violate the nurse practice act. But for your reference, since 2002, less than .01 percent of APRNs have been disciplined by the Board of Nursing (LLR, Board of Nursing, SC. Nurse Practice Act. 92024). (https://www.scstatehouse.gov/code/t40c033.php

The FTC ruled in previous evaluations of scope of practice bills, that restricting what health care professionals can do in practice is anticompetitive and impedes care, impedes access, and drives up cost due to increased regulatory requirements and forcing patients to seek the ER for care. (https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf).

No other professional is dependent on another professional for licensure to practice. Yet, our NPs must hold master's degrees at a minimum, many have doctorates such as myself, must obtain and maintain national certification, and obtain ongoing continuing education with a practice requirement in order to maintain a license (Board of Nursing). But if we don't have written practice agreement, we can't practice or see patients. LLR, Board of Nursing, SC. Nurse Practice Act. 92024). (https://www.scstatehouse.gov/code/t40c033.php).

We know what our limitations are and when to seek a higher level of professional care. Currently, 37 States have full practice authority in some fashion, such as transitioning to full practice authority (National Conference State Legislatures' Map).

4. **Quality and safety**

Decades of research and data support that NPs, CNMs, and CNSs have excellent outcomes, especially with managing patients who have chronic diseases such as HTN, DM, Depression, COPD, CKD. This research comes from external nursing scholars, CMS, and the Federal GOVT such as the VA and Office of Technology Assessment. The same holds true for safety. Years of research and data support that NPs, CNMs, and CNSs are safe providers, even safer in their prescribing habits than physicians. This research comes from external nursing scholars, CMS, and the Federal GOVT such as the VA and Office of Technology Assessment. Here are some examples. Here are some examples.

AANP State by State Practice Environment, 2023. www.AANP.org;

AANP Literature Review Compilation of Studies on Cost, Safety and Quality of Care by NPs. 2023. www.AANP.or;

Studdert, D. & Huynh, J. (2023). Nurse Practitioners as Safe as Physicians in Prescribing. Annals of Internal Medicine (Oct 23) https://med.stanford.edu/news/all-news/2023/10/nurse-practitioner-prescribing.html;

South Carolina Institute of Medicine and Public Health. (2021, June). *With 20% in SC struggling with mental health, report points to needs for widespread change*. https://imph.org/with-20-in-sc-struggling-with-mental-health-report-points-to-need-for-widespread-change/#:~:text=According%20to%20the%20advocacy%20group,with%20mental%20illnesses%20are%20inadequat;

National Alliance on Mental Illness South Carolina. (2021). https://www.nami.org/wp-content/uploads/2023/07/SouthCarolinaStateFactSheet.pdf;

Bae, K., Norris, C., Shakya, S., & Timmons, E. (2024). Advanced Practice Registered Nurse Full Practice Authority, Provider Supply, and Health Outcomes: A Border Analysis. *Policy, politics & nursing practice*, *25*(1), 6–13. https://doi.org/10.1177/15271544231212155;

Fenton, A., Humphrey, K. G., Goode, C. K., Celius, L., & Rohde, A. (2024). Mental Health Access to Care: Nurse Practitioner–Led Telehealth Practice. *Journal for Nurse Practitioners*, *20*(4), 104965-. https://doi.org/10.1016/j.nurpra.2024.104965.

5. **Collaborate on Senate bill 45**

   None-the-less, we extended an olive branch to SCMA back in August 2024 but received no response. Senator Davis and Representative Mark Smith received copies of our letter whereby we asked SCMA to sit down with us to have conversations about our bill and to discuss their concerns but no response.

   We would ask again that you all, SCMA, SCNA, SCHA, and the Coalition for Access to Health Care work together on language in Senate Bill 45 that is acceptable but more importantly, meets the needs of our patients and South Carolinians.

   What are the key points on Senate Bill 45:

   What has changed?

1. Removes practice agreements for NPs, CNMs, and CNSs who have at least 4000 practice hours post-graduation from the advanced practice program (Masters or Doctorate) and hold an unencumbered license to practice as NP, CNM, or CNS in SC.
2. Adds language that NPs, CNMs, and CNSs can sign incontinence supply forms and other forms, including determining medical necessity, as authorized by the SC Department of Health and Human Services (SC DHHS). Incontinence supply forms were updated by the SC DHHS in March 2024 to add NPs, CNMs, and CNSs as ordering providers for incontinence supplies.
3. Adds language that NPs, CNMs, and CNSs can certify that school employees are TB negative or positive. RNs and NPs, CNMs, and CNS have been reading, signing, and certifying TB forms for other employees (state and commercial employees, volunteers, etc.) for over 50 years.

4. Adds language for defining Full Practice Authority (for NPs, CNMs, and CNSs with more than 4000 hours post-graduation). This means that NPs, CNMs, and CNSs can continue to assess, diagnose, and treat patients without practice agreements but within their scope of practice as recognized by the Board.
5. Adds language that the NP can continue to engage in ionized fluoroscopy, which NPs are currently doing in acute care or diagnostic centers.
6. Adds language that the NP or CNS can sign commitment papers if the patient is deemed a danger to himself or others. Currently, NPs and CNSs serve as designated examiners for the state that determine if a patient is a danger to themselves or others for commitment or releasing a patient from a psychiatric facility.
7. Because pharmacists may not be on site in a birthing center, language is added that the CNM can order, prescribe, and dispense C2 Medications at a licensed Birthing Center.
8. Removes language that Medical Board jointly approves medical acts for the NP, CNM, or CNS who has full practice authority, but that language will remain if the NP, CNM, or CNS is under a practice agreement. The Board of Nursing retains authority over all NPs, CNMs, and CNSs for scope of practice, which is based on national certification, successful graduation from an accredited APRN program, and national standards of practice by the National Council of State Boards of Nursing.

What did not change?

1. NPs, CNMs, and CNSs with less than 4000 hours of advanced practice post-graduation remain under practice agreements with their physician/medical staff.
2. The definition of practice agreements did not change.
3. The ratio of a collaborating physician to NPs, CNMs, or CNSs under practice agreements did not change.
4. There is no change in the telehealth provisions.
5. The collaborating physician(s) continues to agree to medical acts that the NP, CNM, or CNS can do under the practice agreement.
6. The collaborating physician(s) remains responsible for the quality assurance and care delivered by the NP, CNM, and CNS under the practice agreement.
7. There are no changes in prescriptive authority, including those under practice agreements and those with Full Practice Authority. Currently, NPs, CNMs, and CNSs can prescribe C2-C5 narcotic medications and non-narcotics.
8. All NPs, CNMs, and CNSs must continue to practice in rural areas or underserved in urban areas.
9. There are no changes in the requirements for licensure for an NP, CNM, and CNS, including those under practice agreements (except for 4000 hours requirement) and those with Full Practice Authority.

10. NPs, CNMs, and CNSs remain under the licensing authority of the Board of Nursing authority.
11. All NPs, CNMs, and CNSs must achieve and maintain national certification.
12. There are no changes in the requirements for continuing education for NPs, CNMs, and CNSs.

6. All the while, I get asked this question a lot: What is the difference between the NP and Primary Care MD? THINK of the ANSWER AS A PERL:

Practice:

The lines have become more fluid over the years as the NP, CNM and CNS roles have evolved in primary care practice. Both the NP and MD see the patient, conduct history and physical exams, make diagnoses, and prescribe a plan of care to include medications, patient teaching/counseling, referring the patient for labs and/or specialists, and provide follow-up.

Both prescribe all medication categories and can perform simple office procedures such as biopsies. Under CMS rules, NPs can act as providers in hospice for end-of-life care.

What NPs cannot do: Surgery, Colonoscopies, cannot prescribe controlled substances for acute pain for more than five days, can't perform C-sections, and we do not manage unstable health conditions such as an acute heart attack in the office setting, spontaneous bleeding in a pregnant woman, uncontrolled seizures in the office setting, etc.

Education:

Table 1: Education Comparison

	Clinical hours before entering the program?	**Clinical hours during the program?**	**Clinical hours post-graduation to practice without a practice agreement?**	**Clinical hours post-graduation for residency**	**Must achieve national certification upon graduation in order to practice?**
NP, CNM, CNS	**RN entering the program has average of 10,000 (5 years) hours as an RN but clinical**	**1000 hours**	**4000 hours**	**4000 hours (for transition to full practice. Otherwise, practice in collaboration).**	**Yes**

	practice is not a requirement before entering APRN program (NP, CNM, CNS).				
Physician	**None**	**None, though some medical schools offer some observation clinical.**	**NA**	**6000 hours, but it depends on the residency**	**No**

Reimbursement:

I have already presented this but to reiterate: 80-85% of what the physician charges is reimbursed by the payer to the NP. For example: If the physician charges $100 for the visit, and CMS deems that the visit is actually worth $80 dollars to reimburse the physician, then the NP receives $64, which is 80% of $80 dollars. The NP cannot bill the patient for the additional dollars, but the physician can bill for those dollars.

Liability:

Senate bill 45 requires all APRNs (NP, CNM, CNS) to carry liability insurance. My liability insurance is $1490 per year (www.proliability.com)

7. Finally, we want to say a few words about Senate Bill 669.

We have many concerns. Here are some:

- Team based care should be patient driven and centered.
- If a Volunteer Committee has to approve collaboration fees and practice agreements for NPs/CNMs/CNS who own a practice in full or partially, what are the logistics for doing so? How many, when, and what?
- The Volunteer Committee will review any or all practice agreements. What are the logistics for that review? How many, when, and what? There are 7000 NPs in the state with collaborative practice agreements. If that volunteer Committee works 5 days per week, 50 weeks per year, that's 250 working days. That Committee would have to review for approval at least 28 practice agreements per day. How long do NPs wait on their approval? Weeks, months, or one year?

- The Committee will conduct hearings? That is currently done by the Office of Compliance within LLR. Panel hearing members are approved by the Office of Compliance at LLR.
- The composition of the Volunteer Committee is comprised of 5 physicians and only 2 APRNs? We would want the Committee comprised of at least 5 APRNs.
- What is the taxpayer cost of Senate Bill 669 implementation?
- What happens if my practice agreement approval process is delayed? Who pays for my practice when it is out operation? Who pays the ER visit when the patient can't access me for care because I am waiting for approval of my practice agreement.
- LLR has never approved the practice agreement. They do conduct site visits and conduct random audits. This bill takes SC backwards after years of solid evidence the NPs are safe, increase access, and improve outcomes.
- This bill places undue burdens on practicing physicians. Who pays for them to have "administrative time off" to conduct audits and onsite visits. My physicians are so busy, the reality is they don't even have time now.

We are simply asking to remove practice agreements for experienced NPs, CNMs, and CNSs so we can continue to penetrate rural and underserved areas, even in urban areas where pockets of underserved populations exist. We support Senate Bill 45 and ask that you all table Senate Bill 669. We are asking in Senate Bill 45 to have written practice agreements removed for **experienced NPs, CNMs, and CNSs**. What does experience mean: 4000 hours post-graduation in clinical practice as NP, CNM, or CNS. And to authorize that facilities such as hospitals create their own policies and procedures for credentialing a provider such as NP.

Thank you for allowing me to speak on behalf of the 7000 NPs in the state. Senate bill 45 is critical to SC for saving money, improving outcomes, and increasing access. Senate bill 669 imposes another regulatory layer and places undue burdens on physicians, facilities, and APRNs which ultimately impacts patients and taxpayers. We have put together a binder that hopefully answers your concerns and questions, as well as addresses SCMA claims about NPs. Please let us know if we can answer any questions.

Respectfully,

Stephanie Burgess, PhD, APRN, FAAN, FAANP
2065 Shull Ave
Gilbert, SC 29054
803-530-9899 Cell

scburgess@aol.com
Vice Chair, Coalition for Access to Health Care
Past President, SCNA and SC Coalition for NPs