HB 1996/SB 1207 An Act To Remove Restrictions on the Licenses of NPs and CRNAs as Recommended by the Institute of Medicine and the Federal Trade Commission


ISSUE: Antiquated mandates in the Massachusetts Nurse Practice Act have restricted the ability for nurse practitioners (NPs) and certified registered nurse anesthetists (CRNAs) to improve access to quality, cost effective healthcare services. In 2010, the Institute of Medicine released a report noting the negative impact of these restrictions to meet those goals and issued a set of recommendations ranking the removal of these artificial barriers by state legislatures as its number one priority.

MASSACHUSETTS LAW: For over 20 years, the MGLs have tied the Massachusetts Board of Registration in Nursing to promulgating regulations jointly with the Massachusetts Board of Registration in Medicine in relation to advanced practice nurses. The law mandates that an individual physician determine what a NP or a CRNA “may” do by requiring an individual set of practice guidelines, versus what they “can” do based on their professional standards and education. This limitation is a condition of that licensed nurse’s professional authorization in order to care for patients. It also mandates that a physician must retrospectively review a sub-set of the prescriptions issued to patients by NPs and CRNAs. This review designates that physician as a “supervising physician” in the statute, but this is a misnomer as there is no real time supervision of the individual NP or CRNA’s caring for patients. In fact the physician is not even required to be on-site.

Professional licensure is an earned privilege, a protected property right and a responsibility awarded by state licensing boards as an affirmation of competence in a particular profession or occupation. The Massachusetts framework for licensure of NPs and CRNAs creates an erroneous perception that licensed NPs and CRNA’s can’t be trusted to do well by patients and must be governed by another discipline. This framework does not exist for other licensed disciplines making up the health care team, such as psychologists, social workers, physical therapists, podiatrists or optometrists. Decades of care delivery and volumes of evidence based research demonstrate that NPs and CRNAs excel in delivering high quality care. In addition, there is no data to substantiate that Massachusetts' licensure framework either enhances patient safety or reduces health care costs. The Institute of Medicine, the American Association of Retired Persons (AARP), the National Governors’ Association (NGA) and many national organizations recommend it be eliminated. In fact, the Federal Trade Commission (FTC) issued an opinion letter to the Massachusetts Legislature in January 2014 supporting the IOM recommendations to remove such barriers.

APPLICATION OF THE LAW TO PRACTICE: Massachusetts’ licensure structure has created a web of individual physician control over individual advanced practice nurse licensees. The NP and CRNAs’ ability to care for patients while practicing to the full extent of their education and training should be based upon the evaluation by delivery systems on how to best to deploy the knowledge and skills of NPs and CRNAs. Some of the negative consequences of the current Practice Act include:

- Obstruction of NPs from practicing as primary care providers;
- Only 51 CRNAs have been allowed to write prescriptions for the patients they see¹;
- Restrictions on CRNA prescriptive practice to within 24 hours of surgery when patients’ pre-operative work ups are routinely conducted more than a day before surgery;

¹ Department of Public Health, Prescription Monitoring and Drug Control Program, data release March 18, 2014
Engaging billing practices that obscure the services rendered by NPs and CRNAs, which increases costs to the health care system and decreases transparency;

Preventing test results from being sent to the ordering NP or CRNA;

Promoting a false perception that "supervising" physicians will be liable for care delivered by NPs and CRNAs who are required to carry their own liability insurance and are already directly accountable for the care they deliver;

Aligns Massachusetts with Delaware and Alabama as the only states in the country with oversight by the Board of Registration in Medicine over the Board of Registration in Nursing;

Repeated attempts by the BORM to create additional burdensome requirements on physicians that would discourage them from choosing to have CRNAs as part of their surgical team, e.g. ophthalmologist or surgeon in an ambulatory care setting;

BORM issuing instructions to funeral directors to not accept death certificates signed by NPs;

Legal omission of NPs and CRNAs from mandatory participation in the state’s prescription monitoring program thus obscuring the NP or CRNA’s prescriptive practices;

Inhibition of new practice models to address health care delivery reform goals;

Obstruction of claims data reflecting NP and CRNA care and its collection and eventual analysis by the All Payer Claims Data Base;

Maintaining a “cottage industry” where individual physicians receive direct revenues in exchange for signing off on a written collaborative practice agreement and serving as the “supervising physician” engaged in retrospective reviews of prescriptions issued to patients by the NP or CRNA.

**SOLUTION:** Massachusetts is the only New England state that has not yet removed these restrictive and artificial barriers to our practice. Providing patients with full and direct access to NPs and CRNAs does not mean these clinicians will practice in isolation. Like physicians and other colleagues they will continue to practice as part of multidisciplinary teams that encourage and rely upon true collaboration, but with the “individual authority” to provide their own expertise consistent with national standards. This legislation brings the balance of accountability, safety and flexibility that Massachusetts needs to successfully meet workforce demands, gaps in access to care and adapt to changing healthcare delivery models that will meet patients’ needs.

Aligning the Massachusetts Practice Act with national recommendations for professional licensure will allow NPs and CRNAs to practice to the full extent of their education and training and improve the quality of care while reducing costs.

**Goals of HB 1996/SD 311 An Act to Remove Restrictions on the Licenses of NPs and CRNAs as Recommended by the Institute of Medicine and the Federal Trade Commission are to:**

1. Remove the mandate that physician approval is required to determine what a NP or CRNA “may do” versus allowing state professional licensure to regulate what they “can do” by virtue of their education and national certification;

2. Remove the mandate of “supervision” by a physician for the prescriptive practice and the retrospective review of prescriptions already written for patients by the NP and CRNA;

3. Provide the sole authority for the regulation of NPs and CRNAs to the Board of Registration in Nursing;

4. Remove the restrictive time limitations on issuing prescriptions by the CRNA and

5. Update the Nurse Practice Act to reflect that NPs and CRNAs not only order tests and therapeutics, they also interpret them in order to best treat the patient.

**Legislators, for more information contact: Craven & Ober Policy Strategists, LLC at 617-523-6501**