Nurse Practitioners--Plenary Authority Bill

Problem Statement
Texas is locked in a health care delivery crisis with limited resources and a rapidly growing population with complex health needs. Providing quality, affordable access to health care requires an adequate direct care workforce. The Texas Medicaid enrollment rate is unmanageable even without taking federal health care reform into account. The cost of the Medicaid program is increasing at a rapid rate and cannot be sustained or increased to meet federal requirements without imposing crushing financial burdens on Texas residents.

In Texas, state law prohibits Advanced Practice Registered Nurses (APRNs) from practicing to the full extent of their education and clinical ability. Currently, Texas requires physicians to delegate authority to APRNs in order for APRNs to practice. Physician supervision requirements vary based on the APRN’s practice setting, but the various requirements create a complicated regulatory scheme, which restricts patients’ access to care. For example, current law requires APRNs to practice within 75 miles of a supervising physician; with few physicians opting to practice in rural areas, many APRNs who are willing to work in rural areas are essentially prohibited from delivering care to these underserved areas.

Texas’ rapid growth, aging population and physician shortage requires changes in the current statutory requirements relating to APRN authority. If changes are not made, Texans will be denied access to vital health care.

How to Address the Problem?
The Texas Nurse Practitioners firmly support allowing APRNs to practice to the full extent of their clinical ability without ANY arbitrary barriers.

- Texas ranks 42nd in the ratio of physicians per 100,000 population and 47th in the ratio of primary care physicians per 100,000 population. Conservative estimates anticipate that 1.8 to 2.3 million Texans will be added to the Medicaid and CHIP insurance rolls with implementation of health care reform. While only 9% of medical school graduates went into primary care in 2009, 80% of the NP workforce is in a primary care setting. (NCSL, More Patients Under Federal Health Reform with Fewer Primary Care Doctors Spell Trouble, December 2010)

- Studies show that increasing access to health care providers will decrease costly hospitalizations; a 1% increase in the primary care physician to total physician ratio leads to a reduction of 0.65 inpatient and 3.83 ER admissions per 1,000 population. (Kravet, S. J., Shore, A. D., Miller, R., Green, G. B., Kolodner, K., & Wright, S. M. (2008). Health Care Utilization and the Proportion of Primary Care Physicians. The American Journal of Medicine, 121(2), 142-148). NPs have the training and clinical ability to provided many of the services delivered by primary care physicians.

- The Federal Trade Commission, when asked to review the competitive impact of removing statutory restrictions on APRNs, noted, “requiring supervision of APRNs imposes costs on Texas health care consumers.” In addition, FTC “urged” the removal of restrictive statutes expecting the change would play an important role in improving access to health care services by Texas consumers.

- Hundreds of studies on the quality of NP care have been conducted over the past 40 years. Repeatedly, when the quality of NP care has been assessed in studies that are highly rated on strength of evidence, NP providers have been found to provide equivalent, and in some cases, superior care to that provided by physicians. (Josiah Macy Foundation, Who Will Provide Primary Care and How Will They Be Trained?, April 2010)

- At a minimum, a nurse practitioner (NP) must earn a master’s degree, however, a growing number of NP programs prepare NPs to a doctoral level. In addition, NPs are required to have a current RN license and clock a minimum of 500 clinical hours.

Who benefits if these Regulations Change?
- Texas will save money as a direct result of the increase in primary care providers; an increase in providers reduces the amount of expensive hospitalizations and ER visits that result when patients do not have access to a primary care. Additionally, a larger number of APRNs will bill under their own billing numbers at a reduced reimbursement rate—leading to further cost savings for the state.

- Texans, in both rural and urban areas, will enjoy increased access to vital care.

- APRNs, who left their home state of Texas, will return and provide the care they are educated to perform. APRNs, who could not find a supervising doctor or could not afford to pay for supervision, will be able to serve the patients they have been willing, but unable to treat.

Consequences if Nothing Happens?
A valuable opportunity to address Texas’ health care delivery crisis will be lost. The state’s aging and growing population, shortage of providers, and ever-increasing Medicaid enrollment requires the state implement every safe and cost-effective measure that will increase access to care. If the arbitrary restrictions are not removed, the growing gap between the supply of care and demand will continue to expand at an unmanageable rate. Texans will encounter exorbitant wait times to see a physician and Medicaid patients will have trouble finding a physician willing to treat them at all. This lack of access will lead to higher utilization of ER care and, in turn, higher costs.

Who Already Grants APRNs Plenary Authority?
17 states and the District of Columbia have already removed arbitrary and outdated restrictions and grant APRNs plenary authority to practice to the full extent of their graduate-level education; these states do not require any physician involvement. Additionally, 19 states allow for a lesser form of collaboration.

82nd Legislative Session
A total of 5 bills were filed in the House and Senate during the 82nd Legislative Session to give APRNs plenary authority. HB 708, HB 1266, and HB 915 would have all created access and cost savings for millions of Texans.

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1 Nurse Practitioners are one type of advanced practice registered nurse (APRN). The APRNs designation also applies to Certified Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNSs). A majority APRNs – 63% – are NPs.