

July 16, 2021

Members of the Massachusetts Board of Registration in Nursing

Dr. Lorena Silva, Executive Director

Massachusetts Board of Registration in Nursing

239 Causeway Street, Suite 500, 5th Floor

Boston, MA 02114

Email: Reg.Testimony@state.ma.us

Re: BORN: 244 CMR 4.00

Dear Executive Director Silva and Members of the Board,

As the professional voice of the more than 12,500 licensed nurse practitioners (“NPs”) in the Commonwealth of Massachusetts, the Massachusetts Coalition of Nurse Practitioners (“MCNP”) thanks the Board of Registration in Nursing (“Board”) for its leadership in implementing the emergency regulations at *244 CMR 4.00: Advanced Practice Registered Nursing* (“Emergency Regulations”). The Board’s prompt response to Governor Baker’s order to lift the COVID-19 State of Emergency has protected access and ensured a smooth transition for patients under the care of Advanced Practice Registered Nurses (“APRNs”) who had been practicing independently under the now expired March 26, 2020 Emergency Order suspending supervisory requirements for APRN prescriptive authority. The MCNP commends the Board for its efforts in this regard.

The MCNP is thankful for this opportunity to present comments and concerns to the Board relative to the Emergency Regulations in their current form. At this time, we write to propose changes that we believe are necessary to align the Board’s Emergency Regulations with the goals of their authorizing legislation, *S.2984, An Act Promoting a Resilient Health Care System That Puts Patients First,* which was signed into law by Governor Baker on January 1, 2021. Specifically, we offer the following comments related to the criteria for **Qualified Healthcare Professionals** and **Prescriptive Practice Guidelines**.

1. Qualified Healthcare Professionals
2. Overview of MCNP’s Suggested Revisions

As drafted in the Emergency Regulations, section 4.07(1) adds and defines the role of a “Qualified Healthcare Professional” (“QHP”) for purposes of providing supervision to a Certified Registered Nurse Anesthetist (“CNRA”), Certified Nurse Practitioner (“CNP”), or Psychiatric Nurse Mental Health Clinical Specialist (“PNMHCS”) who seeks independent practice authority. The Emergency Regulations state this supervisor may be either a physician or another APRN, and include requirements for each. The MCNP is

concerned with these requirements as drafted and refers to the Emergency Regulations’ authorizing legislation, *S.2984, An Act Promoting a Resilient Health Care System That Puts Patients First,* which amended M.G.L. c. 112, §§ 80B, 80E, 80H, 80I, 80J, and 80K to authorize the independent practice for CRNAs, CNPs, and PNMHCSs.

With regard to the discussion of QHPs, the amended statutes require that the Board set forth minimum qualification criteria for supervising healthcare professionals and that such qualification criteria “include a minimum number of years of independent practice authority” for supervising APRNs. The statute itself, however, does not require any other substantive clinical qualifications. To this point, the MCNP is concerned that the Emergency Regulations, as currently drafted, as they relate to QHPs are restrictive and are inconsistent with the intent of the legislation. Specifically, the MCNP is concerned that the Emergency Regulations include more qualifications for QHPs than the amended statutes require and that these additional requirements have the potential to substantially limit the pool of physicians and APRNs who may serve in a supervisory capacity and, thereby, negatively impact patient access to care in the Commonwealth by artificially narrowing the APRN workforce.

Accordingly, the MCNP urges the Board to revise the requirements at 244 CMR 4.07(1) as follows:

For purposes of 244 CMR 4.07, a Qualified Healthcare Professional means a person who meets the following criteria:

1. A physician who:
2. holds an unrestricted full license issued by the Board of Registration in Medicine (BORIM) that is in good standing; and
3. ~~is Board-certified in a specialty area appropriately related to the APRN’s area of practice, or has hospital admitting privileges in a specialty area~~ **has clinical experience** ~~appropriately~~ related to the APRN’s area of practice; and
4. holds a valid controlled substance registration issued by the U.S. Drug Enforcement Administration, or the Department of Public Health, or both.
5. A CRNA, CNP or PNMHCS who holds:
6. a valid Registered Nurse license in good standing issued by the Board; and
7. advanced practice authorization issued by the Board that it is in the same clinical category as the person being supervised **or has clinical experience related to the APRN’s area of practice**; and
8. a controlled substance registration issued by the U.S. Drug Enforcement Administration, or the Department of Public Health, or both~~, for a minimum of one year~~; and
9. either
	1. a combination of supervised practice for a minimum of two years plus independent practice authority for a minimum of one year, or
	2. ~~three years of independent practice authority~~ **alternative professional experience as determined by the Board, which shall include, without limitation, CRNAs, CNPs and PNMHCSs with at least three years of prior supervised practice or two years of independent practice.** [[1]](#footnote-1)
10. Discussion Regarding Suggested Revisions to Criteria for Physician QHPs

The MCNP believes that the Emergency Regulations, as currently drafted, limit the availability of qualified physicians who may serve as QHPs by requiring Board certification or hospital admitting privileges in a specialty area appropriately related to the APRN’s practice. The MCNP urges that this requirement is outside the bounds of what is required by the amended statutes, excessive for purposes of independent APRN prescribing and ordering tests and/or therapeutics, and will make it more challenging for APRNs to find physician QHPs, particularly in provider shortage areas that exist throughout the Commonwealth and in behavioral health where there is a paucity of willing psychiatrists. Rather than being able to obtain supervision from any physician who has clinical experience related to the prescriptive practice of the APRN, the Emergency Regulations as drafted will limit an APRN to seeking supervision from only those physicians in the same specialty area, regardless of whether physicians outside the specialty would be so qualified. The proposed revisions as outlined above recognize the potential value of consultation if needed with a QHP with related clinical experience while still aligning with the legislative intent to provide the greatest amount of flexibility and further patient access to care from independent APRNs.

1. Discussion Regarding Suggested Revisions to Criteria for APRN QHPs

Likewise, the MCNP believes that the Emergency Regulations as currently drafted limit the availability of APRNs who may serve as QHPs by requiring, without exception, that the supervising APRN and the applicant APRN be in the same “clinical category.” Under this requirement, a psychiatric Clinical Nurse Specialist (“CNS”) would not be able to serve as a QHP for a psychiatric CNP despite having clinical experience related to the psychiatric CNP’s area of practice that would qualify them to supervise the psychiatric CNP. In accordance with these concerns, the MCNP strongly urges the Board to revise the language in the Emergency Regulations in a manner that expands the pool of qualified, available APRN supervisors as much as possible. In particular, the MCNP suggests revising the Emergency Regulations as outlined above to allow for QHP eligibility through clinical category match or related clinical experience. The MCNP believes that adopting this more flexible language retains the discretion granted to the Board while keeping with the legislative intent to improve access to care.

1. Discussion Regarding Suggested Revisions to Minimum Years of Independent Practice

Finally, the MCNP believes that the Emergency Regulations as currently drafted further limit the availability of APRNs who may serve as QHPs by delaying for one year the eligibility of experienced and qualified APRNs to serve in this role. For an APRN with more than twenty years of experience, this requirement translates to a one-year delay before they are eligible to serve as a QHP. Further complicating this issue is the fact that APRNs who were eligible for independent practice authority under the March 26, 2020 Emergency Order Authorizing Independent Practice of APRNs and practiced independently until it expired on June 15, 2021, were only recently able to amend their Massachusetts Controlled Substances Registration to indicate their independent status. If these same APRNs apply for independent practice authority now, they will also need to wait one year before being eligible to serve as a QHP.

MCNP’s proposed revisions to the Emergency Regulations in section 4.07(1) preserve the statutory requirement that the Board include a minimum number of years of independent practice authority in its rulemaking for APRNs to serve as QHPs, while also granting the Board with an alternative option to use its discretion to grandfather APRNs with other experience. This alternative option is important with regard to out-of-state APRNs and, as noted above, APRNs that have practiced for several years albeit without independent practice authority. Accordingly, the MCNP strongly urges the Board to revise the Emergency Regulations to include this proposed language.

1. Prescriptive Practice Guidelines
2. Overview of MCNP’s Suggested Revisions

In addition to concerns outlined above related to QHPs, the MCNP is also concerned with the proposed language in the Emergency Regulations related to prescriptive practice guidelines. Specifically, the MCNP is concerned with the language around delegation and signature. To these points, the MCNP again refers to the language and intent of the authorizing legislation, and proposes revisions to the requirements at 244 CMR 4.07(2) as follows:

CRNAs, CNPs or PNMHCSs with less than two years of supervised practice experience, or its equivalent, may engage in prescriptive practice with supervision by a Qualified Healthcare Professional. CRNAs, CNPs or PNMHCSs with less than two years supervised practice will develop mutually agreed upon guidelines with the Qualified Healthcare Professional which will:

1. identify the supervising Qualified Healthcare Professional~~, including a defined mechanism for the delegation of supervision to another Qualified Healthcare Professional, including but not limited to, duration and scope of the delegation~~;
2. describe circumstances in which Qualified Healthcare Professional consultation or referral is required;
3. **for CNP and PNMHCS guidelines, be mutually signed by the CNP or PNMHCS and the supervising Qualified Healthcare Professional.** CRNA guidelines do not need to be signed**;**~~. CNP and PNMHCS guidelines shall be signed. The guidelines will be kept on file in the workplace; and~~
4. be kept on file in the workplace; and
5. **5.** conform to M.G.L. c. 94C, the regulations of the Department of Public Health at 105 CMR 700.000 *et seq.*, 105 CMR 721.000 et seq., M.G.L. c. 112, §§ 80B, 80E, 80H, 80I, and the regulations of the Board of Registration in Nursing at 244 CMR 4.00.

The Board may request at any time an opportunity to review the APRN prescriptive practice guidelines. Failure to provide guidelines to the Board is a basis for and may result in disciplinary action. The Board may require changes in the guidelines if it determines that they do not comply with 244 CMR 4.00 and accepted standards of nursing practice. [[2]](#footnote-2)

1. Discussion Regarding Suggested Revisions to Criteria for Prescriptive Practice Guidelines

As outlined above, the first revision that MCNP recommends relates to the proposed requirements around delegation and alternative QHPs. As drafted in the Emergency Regulations, section 4.07(2) requires that the prescriptive practice guidelines not only identify the supervising QHP, but also include “a defined mechanism for the delegation of supervision to another Qualified Healthcare Professional, including but not limited to, duration and scope of the delegation.” However, the amended statutes do not include any such requirements around specific procedures for delegation or alternative QHPs. Rather, the amended statutes simply read: “A [NP] or [PNMHCS] may issue written prescriptions and medication orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the nurse and a supervising [NP] who has independent practice authority, a supervising [PNMHCS] who has independent practice authority or a supervising physician, in accordance with regulations promulgated by the board.” While the MCNP recognizes and appreciates that the amended statutes give the Board the authority to promulgate regulations regarding the prescriptive practice guidelines, the MCNP is concerned that the inclusion of the proposed regulatory language around delegation and alternative QHPs may limit patient access capabilities by imposing additional restrictions around supervision and, therefore, does not align with legislative intent. Accordingly, the MCNP urges the Board to revise the Emergency Regulations in a manner that simplifies for items not required by the amended statutes, such as delegation and alternative QHPs, and retains the flexibility provided in the legislation for prescriptive practice guidelines. In particular, we suggest that the Emergency Regulations be amended as outlined above to remove the language relative to procedures for delegation and alternative QHPs.

Additionally, the MCNP recommends revision to the Board’s proposed language around signature of prescriptive practice guidelines. The MCNP is supportive of the requirement, contained both in the Board’s Emergency Regulations and the amended statutes, that CNP and PNMHCS prescriptive practice guidelines be signed. However, the MCNP requests that the Board revise its proposed language to further clarify that the guidelines must be codified by mutual signature of both the applicant CNP or PNMHCS and the supervising QHP. Such clarification will ensure that the regulatory language is consistent with the statutory language which requires guidelines be “developed and signed mutually” by both the applicant CNP or PNMHCS and the supervising QHP. Accordingly, the MCNP recommends that the Board revise its Emergency Regulations as outlined above.

1. Concluding Remarks

On behalf of the MCNP, I would like to thank you again for your leadership in reforming the Commonwealth’s rules around independent practice authority for APRNs. We appreciate the opportunity to provide feedback to these Emergency Regulations as well as your consideration of our comments, which are grounded in our mission to advance NP practice and our vision for health equity, cost savings, and optimal wellness for the residents of the Commonwealth of Massachusetts. Please feel free to contact me with any questions.

Sincerely,



Stephanie Ahmed, DNP, NP-BC

State Legislative Policy Director

Massachusetts Coalition of Nurse Practitioners

P.O. Box 1153

Littleton, MA 01460
Email: stephanie.ahmed@gmail.com

1. Black text = currently published Emergency Regulations.

 Red text = MCNP’s suggested language for deletion.

 **Blue text** = MCNP’s suggested language for insertion. [↑](#footnote-ref-1)
2. Black text = currently published Emergency Regulations.

 Red text = MCNP’s suggested language for deletion.

 **Blue text** = MCNP’s suggested language for insertion. [↑](#footnote-ref-2)