COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Scope of Practice and Cost-Effective Care Delivery in Massachusetts

October 5, 2015
“Scope of Practice” laws

- Define legal boundaries and operational restrictions on practice for some categories of health care providers – particularly where training and practice overlap with other providers, e.g.,
  - Nurse Practitioners
  - Nurse Anesthetists
  - Dental Hygienists
  - Optometrists
  - Psychologists

- Scope of Practice laws are the purview of state legislatures and aim to balance concerns of safety, access, costs and competition

APRNs also include Nurse Midwives and Clinical Nurse Specialists
**Scope of Practice laws concerning Advanced Practice Registered Nurses**

- Generally take the form of limitations on practice authority
- State legislatures and researchers have been reassessing the evidence base concerning these laws
- Massachusetts has among the most restrictive laws in the nation
- By preventing providers from practicing to the full extent of their licenses and training, these laws may represent an unnecessary barrier to cost-effective care
Nurse Practitioner practice characteristics (U.S., 2012)

- NPs are Advanced Practice Registered Nurses (APRNs) who have completed a Master’s or Doctorate with required clinical hours and passed a national certification exam.
- There are 127,000 NPs in patient care in the US; 60,000 in primary care; ~5,000 in MA.
- Median earnings (NPs in patient care): $87,000.
- 89% work in settings with a physician on site.
- Medicare pays 85% of the physician fee; other payers vary from ~75-100%.

### Practice settings of U.S. NPs

- Private physician practice: 32%
- Hospital Inpatient: 13%
- Hospital Outpatient: 11%
- Community/federal clinic: 11%
- Long-term care: 8%
- Private NP office/practice: 4%
- Urgent care/retail clinic: 4%
- Mental health setting: 1%
- Other: 16%
## NPs provide high quality care

Quality and outcomes of care provided by NPs relative to that provided by primary care physicians: literature review, 1980-2008

<table>
<thead>
<tr>
<th>Outcome</th>
<th># of studies</th>
<th>Result</th>
</tr>
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<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>6 (4 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Self-reported health status</td>
<td>7 (5 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Functional Status</td>
<td>10 (6 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Glucose Control</td>
<td>5 (5 RCTs)</td>
<td>Equivalent or favoring NPs</td>
</tr>
<tr>
<td>Lipid control</td>
<td>3 (3 RCTs)</td>
<td>Favoring NPs</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>4 (4 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>ED/urgent care visits</td>
<td>5 (3 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>11 (3 RCTs)</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Mortality</td>
<td>8 (1 RCT)</td>
<td>Equivalent</td>
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</tbody>
</table>

NPs are more likely than physicians to treat vulnerable populations

Survey of ~2,000 primary care physicians and primary care nurse practitioners; 61% response rate

- 66% of NPs vs. 57% of physicians accepting new Medicaid patients
- 34% of NPs vs. 22% of physicians treating more than 25% of patients as minorities
- 62% of NPs vs. 50% of physicians in urban or rural practice settings

Costs of care provided by NPs are generally lower

Prominent findings from the literature

- **Direct costs of primary care visits**
  - Lower labor costs in Kaiser system for visits to NPs or PAs (Roblin et al., 2004)
  - ~35% lower visits costs in Massachusetts (RAND, 2009)

- **Total costs including subsequent care**
  - Higher resource use in 3 categories among 150 VA patients randomized to providers (Hemani et al, 1999)
  - Lower costs (Medicare Part B; 29% lower, Medicare Part A; 11% lower) among ~600,000 Medicare beneficiaries (Perloff et al., 2015) with NPs as their PCP

Perloff, DesRoches, Buerhaus et al., Forthcoming in Health Services Research, 2015
Types of Scope of Practice laws governing Nurse Practitioners

- Requirements to maintain a collaborative agreement with a physician* to:
  - Prescribe drugs
  - Provide care
- Requirements to practice within some distance from the collaborating physician
- Requirements to follow certain treatment protocols
- Inability to sign death and disability forms
- Required approval by the State Board of Medicine for implementation of new practice authority

*Nurse Practitioners often pay physicians on the order of several hundred to several thousand dollars per month under these agreements
Independent bodies have recommended easing or removal of practice restrictions

<table>
<thead>
<tr>
<th>Selected findings from the Federal Trade Commission (2014) Staff Paper</th>
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<tbody>
<tr>
<td>▪ Collaboration and professional oversight among NPs and physicians are the norm, whether required or not</td>
</tr>
<tr>
<td>▪ No evidence of harm or risks from APRN prescribing</td>
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<tr>
<td>▪ Supervision requirements may “constrain [providers] in their ability to develop and implement more variable or flexible models of team-based care, consultation, and oversight, according to patient needs and institutional needs and resources.”</td>
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<tr>
<td>▪ “Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition.”</td>
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</tbody>
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States have increasingly removed these restrictions

Number of states that allow full practice authority for nurse practitioners

Despite incremental changes in 2008, 2010 and 2012, Massachusetts remains a restrictive state

<table>
<thead>
<tr>
<th>Restriction</th>
<th>Year removed/still in place</th>
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<tbody>
<tr>
<td>NP recognized as PCP that patients can choose</td>
<td>2008</td>
</tr>
<tr>
<td>Systems and plans can’t refuse to contract with entire categories of providers</td>
<td>2010</td>
</tr>
<tr>
<td>Ability to sign death and disability forms</td>
<td>2012</td>
</tr>
<tr>
<td>Requirements to follow treatment guidelines established by physicians</td>
<td>Still in place</td>
</tr>
<tr>
<td>Required approval by the Board of Medicine for implementation of new practice authority on the part of NPs or other APRNs:</td>
<td>Still in place</td>
</tr>
<tr>
<td>Requirements to maintain a collaborative agreement with a physician to prescribe drugs</td>
<td>Still in place</td>
</tr>
</tbody>
</table>
Massachusetts is currently one of the 12 most restrictive states for NPs

Figure 2

Nurse Practitioner State Practice Environment, 2014

SOURCE: American Association of Nurse Practitioners, 2014

What would be the impact of removal of restrictions in Massachusetts?

**Key findings from the literature**

- **Impacts on health care system (RAND, 2015)**
  - **Access**: likely increase
    - Research finds 2% increase in office visits and reports of more timely and convenient preventive care
  - **Quality and outcomes**: possible increase
    - Data suggest possible improvements in self-reported health and fewer ambulatory-sensitive ED visits
  - **Total spending**: ambiguous
    - Decreased prices and payments from NPs to physicians; increased spending due to more visits

- **Impact on supply of NPs (Kalist and Spurr, 2004)**
  - 30% higher supply of APRNs in states without restricted practice

Impact of removal of restrictions (cont’d)

Case study from Massachusetts (2013)

- Avoided gaps and disruption of care
  - A Massachusetts private behavioral health clinic staffed with one psychiatrist, 10 APRNs, 3 psychologists and 6 social workers provided care and medication management to more than 1,000 high-needs patients with disorders such as ADHD, bipolar disorder and schizophrenia.
  - The psychiatrist was abruptly terminated – causing an immediate halt to care provision by the APRNs until the practice could find a new physician willing to sign a collaborative agreement.
  - In the two month-gap in care that ensued, many patients had to visit emergency departments to obtain necessary medication.
Summary

- Scope of Practice laws in Massachusetts bear further consideration
- As noted by a Federal Trade Commission Comment on a Massachusetts bill to remove practice restrictions for APRNs (2014)
  - “If APRNs are better able to practice to the extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, Massachusetts health care consumers are likely to benefit from lower costs, additional innovation, and improved access to health care.”
Contact information

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