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Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care¹

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INTRODUCTION

As decision makers at every level wrestle with the urgent need to broaden access to health care, three challenges have become clear. The care provided must be competent, efficient, and readily available at all stages of life; it must come at a cost that both individuals and society at large can afford; and it must allow for appropriate patient choice and accountability. Among the options available to promote these goals, one stands out: wider deployment of, and expanded practice parameters for, advanced practice nurses (APNs). The efficacy of this option is uniquely proven and scalable. These well-trained providers—including nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists—can and do practice across the full range of care settings and patient populations. They have proven to be valuable in both acute and primary care roles, and as generalists as well as specialists.² By professional training as well as by regulatory and financial necessity, they have emphasized coordinated and cost-effective care, and they have tended more than other providers to establish practices in traditionally underserved areas.

The role of any professional group is typically delineated by a process that moves from awareness of capabilities, to acceptance, to acknowledgment and

¹ The responsibility for the content of this article rests with the author and does not necessarily represent the views of the Institute of Medicine or its committees and convening bodies.

² For purposes of this paper, I take it as a given that APNs—like any other appropriately trained and licensed professionals—are able and effective providers within the sphere of their competencies. This has been amply confirmed by numerous studies and analyses over the years, and the literature is readily available.

formal policy making. Despite significant progress in several venues, however, this process has been stymied, in the case of APNs, by the many regulatory obstacles and restrictions that currently impede the full realization of their potential. Chief among these, as I have noted elsewhere, are “conflicting and restrictive state provisions governing [APNs’] scope of practice and prescriptive authority... as well as the fragmented and parsimonious state and federal standards for their reimbursement” (Safriet, 1992). While an extensive catalog of these restrictions appears in the section “Current Impediments in the Regulatory Environment,” the following two examples—one state-based and one federal—will perhaps capture the flavor of the problem.

- In Louisiana, according to the Board of Medicine, no one other than a physician may treat chronic pain, even if the provider in question is trained as a nurse anesthetist, is competent to treat pain, and has been directed to do so by a physician.³
- Medicare precludes a certified nurse specialist from certifying a patient for skilled long-term care, or from performing the physical required for admission, even though the CNS has been treating the patient on an ongoing basis.⁴

THE DIMENSIONS OF THE PROBLEM

There are several steps that the federal government can and should take to eliminate, or at least mitigate, the wasteful effects of such needless restrictions as these. To approach the task effectively, however, decision makers must (1) understand several contextual factors specific to nursing; (2) be familiar with the extensive array of restrictions that are embedded in state and federal regulations (as well as in private organizations’ policies), and grasp their historical origins; and (3) develop a clear understanding of the impediments—ranging from inertia to resistance to active opposition—to a more rational deployment of APNs.

Nurse-Specific Contextual Factors

Any effort to design more effective and cost-efficient health care delivery models by maximizing the contributions of APNs must proceed from a basic understanding of several fundamental aspects of our current framework. Among the most important of these are the following.

1. **The diversity of nursing practice.** “Nursing writ large” encompasses a wide variety of skill levels and roles, and nursing practice routinely takes

³ Louisiana State Board of Medical Examiners: Statement of Position, “Interventional Pain Management Procedures Are Not Delegable,” June 2006.

⁴ *Social Security Act* § 1819(b)(6).

place in an almost infinite variety of settings, ranging from the intensive care unit of trauma centers to schools, patients' homes, prisons, long-term care facilities and nursing homes, community health clinics, and outreach centers. While these diffuse practice settings and roles have no doubt enhanced the nation's health, the very diffusion and multifaceted nature of nursing practice has often meant that nursing has been slighted in the nascent measurement movement which seeks to apply cost and care-effectiveness standards.

2. **Economic invisibility.** Nursing services traditionally have been treated as an expense (albeit an essential one) rather than as an individually identified revenue or income source on institutional or governmental balance sheets. And from the patient's perspective, nursing services rarely, if ever, are separated out from institutional room charges or other professional fees on billing statements. Unsurprisingly, these accounting practices promote the widespread perception that nurses are not "revenue generators" (RWJF, 2010). Perhaps in part because of this "revenue invisibility," nursing has been underrepresented in, or excluded from, the decision-making processes (both private and governmental) that determine the metrics upon which costs, value, pricing, and payment are based. This asymmetrical financial treatment has special salience today, as most reform proposals are focused increasingly on defining the value of services and rewarding the attainment of performance measures. And as APNs continue to participate in, and often lead, the development of innovative practice models designed to better meet patients' needs, it is essential that payment schemes include complete and accurate measurement and valuation of their services.
3. **Multiple routes of entry.** Nursing is the only profession which has multiple educational pathways leading to professional licensure. In all states but one, successful completion of 2-, 3- and 4-year degree programs is recognized as fulfilling the educational requirements for licensure as a registered nurse (RN). This unique multiplicity of qualifying pathways is supported by some, and opposed by others, in the professional, educational, and policy-making arenas, and it will no doubt continue to be assessed as workforce policy focuses on ensuring an adequate supply of well-prepared nurses. Regardless of how this issue is ultimately addressed, however, the current reality is that 2 years of nursing education meets the educational requirement for licensure as a registered nurse, which is the first step for recognition and licensure as an APN. This fact has posed problems for those who seek to promote wider legal authority for, and utilization of, APNs. Even though master's-level education and national certification are now uniformly required for APN licensure,⁵

⁵For a recently adopted uniform framework for APNs, see APRN Consensus Work Group and National Council of State Boards of Nursing APRN Advisory Committee (2008).

policy makers and state legislators are sometimes confused about (or susceptible to opponents' mischaracterizations of) the underlying educational and training requirements when considering expanded recognition of APNs' scopes of practice. While patience and information can overcome most of these concerns, much time and many resources are consumed in the process.

4. **Care versus cure.** As some voices in the current reform debates acknowledge, our emphasis for far too long has been on curing illness, rather than on promoting health. This has led to a systemic overemphasis on training in acute care, technologically robust settings, and to a payment structure skewed toward procedural interventions by increasingly sub-specialized providers. Perhaps unsurprisingly, we have correspondingly undervalued public health. More to the point, we have consistently undervalued coordinated, primary care provided throughout the patient's life spectrum in a variety of settings, including the community, the home, long-term care facilities, and hospice. As a group, APNs have extensive experience across all these settings. Their traditional approach of blending counseling with clinical care, and coordinating health services as well as appropriate community resources in support of patients, could be a model for policies that seek a more optimal balance of providers prepared to meet the needs of the American public.

Regulatory Barriers to the Full Deployment of APNs

Current Impediments in the Regulatory Environment

For health care providers of all types (other than physicians), the framework defining who is legally authorized to provide and be paid for what services, for whom, and under what circumstances is among the most complex and uncoordinated schemes imaginable. It reflects an amalgam of regulations, both prescriptive and incentivized, at the state, local, and federal levels. The effects of these governmental regulations are further compounded by the credentialing and payment policies of private insurers and managed care organizations.

The explicit restrictions resulting from this complex and uncoordinated scheme are many, but they can be grouped into two principal categories: (a) state-based limitations on the licensed scopes of practice for APNs (and other providers) which prevent them from practicing to the full extent of their abilities, and (a) payment or reimbursement policies (both governmental and private) that either render them ineligible for payment, or preclude their being paid directly for their services, or pay them at a sharply discounted rate for rendering the same services as physicians.

In many states, the legal framework authorizing APNs' practices has evolved in step with their expanding skills, education, training, and abilities. In several

other states, however, their full utilization is hampered by outdated (or in some cases newly imposed) restrictions on a full range of professional services. Depending on the jurisdiction, these restrictions may preclude or limit the authority to prescribe medications, admit patients to hospitals or other care facilities, evaluate and assess patients' conditions, order and evaluate tests and procedures, and the like.

To illustrate the pervasive and detrimental variations embodied in many state licensure statutes and regulations, consider the following example.

Imagine an APN who has attended a nationally accredited school of nursing for the BSN and Master of Nursing degrees, and who has passed the national licensure examination for RN licensure as well as national certification examinations in her APN practice area. Imagine further that two adjacent states, A and B, have adopted regulations representing both ends of the regulatory spectrum, and that our APN is licensed in both of them.

In State A, she is permitted independently to examine patients, order and interpret laboratory and other tests, diagnose and treat illness and injury, prescribe indicated drugs, order or refer for additional services, admit and attend patients in a hospital or other facility, and get paid directly for her services.

When she steps across the line into State B, however, it is as if her competence has suddenly evaporated. Depending on her practice area and the particular constellation of restrictions adopted by the legislature of State B, she will encounter many if not most of the following prohibitions.

Examination and Certification

She may not examine and certify for:

- worker's compensation,
- DMV disability placards and license plates, and other DMV testing,
- jury service excusal,
- mass transit accommodation (reduced fares, access to special features),
- sports physicals (she may do them, but can't sign the forms),
- declaration of death,
- school physicals and forms, including the need for home-bound schooling,
- COLST, CPR or DNR directives,
- disability benefits,
- birth certificates,
- marriage health rules,
- treatment for long-term-care facilities,
- alcohol and drug treatment involuntary commitment,
- psychiatric emergency commitment,
- hospice care, or
- home-bound care (including signing the plan of care).

Referrals and Orders

She may not refer for and order:

- diagnostic and laboratory tests (unless the task has been specifically delegated by protocol with a supervising physician),
- occupational therapy,
- physical therapy,
- respiratory therapy, or
- durable medical equipment or devices.

Examination and Treatment

- She may not treat chronic pain (even at the direction of a supervising physician).
- She may not examine a new patient, or a current patient with a major change in diagnosis or treatment plan, unless the patient is seen and examined by a supervising physician within a specified period of time.
- She may not set a simple fracture, or suture a laceration.
- She may not perform:
 - cosmetic laser treatments or Botox injections,
 - first-term aspiration abortions,
 - sigmoidoscopies, or
 - admitting examinations for patients entering skilled nursing facilities.
- She may not provide anesthesia services unless supervised by a physician, even if she has been trained as a nurse anesthetist.

Prescriptive Authority

- She may not have her name on the label as prescriber.
- She may not accept and dispense drug samples.
- She may not prescribe:
 - some (or, in a few jurisdictions, any) scheduled drugs, and
 - some legend drugs.
- She may not prescribe even those drugs that she is permitted to prescribe except as follows:
 - as included in patient-specific protocols
 - with the co-signature of a collaborating or supervising physician
 - if the drugs are included in a specific formulary or written protocol or practice agreement
 - if a specified number or percentage of charts are reviewed by a collaborating or supervising physician within a specified time period
 - if the physician is on-site with the APN for a specified percentage of time or number of hours per week or month
 - if the APN is practicing in a limited number of satellite offices of the supervising physician
 - if the prescription is only for a sufficient supply for 1 or 2 weeks, or provides no refills until the patient sees a physician

- if a prescribing/practice agreement is filed with the state Board of Nursing, Board of Medicine and/or Board of Pharmacy, both annually and when the agreement is modified in any way
- pursuant to rules jointly promulgated by the Boards named above
- if the collaborating or supervising physician’s name and DEA # are also on the script.
- She may not admit or attend patients in hospitals
 - if precluded from obtaining clinical privileges or inclusion in the medical staff,
 - if state rules require physician supervision of NPs in hospitals,
 - if medical staff bylaws interpret “clinical privileges” to exclude “admitting privileges,” or
 - if hospital policies require a physician to have overall responsibility for each patient.

Compensation

- She may not be empanelled as a primary care provider for Medicaid, Medicare Advantage or many commercially insured managed care enrollees.
- She may not be included as a provider for covered services for Workers Compensation.
- She may be paid only at differential rates (65%, 75%, or 85% of physician scale) by Medicaid, Medicare or other payers and insurers.
- She may not be paid directly by Medicaid.
- She may not be certified as leading a Patient-Centered Medical Home or Primary Care Home.
- She may not be paid for services unless supervised by a physician.
- She may indirectly affect the eligibility of other providers for payment because
 - pharmacies cannot get payment from some private insurers unless the supervising or collaborating physician’s name is on the script, and
 - hospitals cannot bill for APNs’ teaching or supervising medical students and residents and advanced practice nursing students (as they can for physicians who provide those same services).

As this example illustrates, the restrictions faced by APNs in some states are the product of politics rather than sound policy. Competence does not change with jurisdictional boundaries; the only thing that changes is legal authority. Indeed, the point is even more sharply illustrated by those states in which an APN’s authorized scope of practice may vary within the state depending on the geographic location of the practice, the economic status of the patient, or the corporate nature of the practice setting. In sum, this practice environment for APNs echoes the conclusion of a previous Institute of Medicine report, which succinctly described the current regulatory framework for health care providers as “inconsistent, contradictory, duplicative, outdated, and counter to best practices” (IOM, 2001). And that disturbingly accurate conclusion was based only upon explicit regulatory

provisions. APNs must also contend with the additional debilitating effects resulting from nursing's traditional "revenue invisibility," and from APNs' absence or exclusion from key decision-making venues such as hospital governing boards and medical staffs and organizations designing quality and cost metrics.

The Costs of This Dysfunctional Regulatory Regime

Even though APNs, like all health professionals, have continued to develop and expand their knowledge and capabilities, the state-based licensure framework described above has impeded their efforts to utilize these ever-evolving skills. For historical reasons that will be explained more fully below, virtually all states still base their licensure frameworks on the persistent, underlying principle that the practice of medicine encompasses both the ability and the legal authority to treat all possible human conditions. That being so, the scopes of practice for APNs (and other health professionals) are exercises in legislative exception making, a "carving out" of small, politically achievable spheres of practice authority from the universal domain of medicine. Given this process, it is not surprising that APNs are often subjected to unnecessary restrictions of the kind I have described. The net result is a distressing catalog of dysfunctions with their attendant costs.

- Because licensure is state-based, there are wide variations in scope of practice across the country for all professions other than physicians. This inconsistency also causes additional problems because payment or reimbursement mechanisms tied to scope restrictions in one state can become the "common denominator" for policies applied across all states. The result is often a "race to the bottom," in which decision makers, for reasons of efficiency and uniformity, adopt the most restrictive standards for payment and practice and apply them even in more progressive states. State A, that is, may be subject to perverse pressures to become more like State B, rather than the reverse. This dynamic has been especially problematic for APNs because they, more than most other providers, have been viewed by some in organized medicine as real or potential economic competitors.
- Access to competent care is denied to patients, especially those located in rural, frontier, or other underserved areas, in the absence of a willing and available "supervising" physician.
- Able providers are demoralized when they cannot utilize the full range of their abilities, and they often relocate to more accommodating states or leave the practice altogether, thus exacerbating the current maldistribution and shortage of providers (Huang et al., 2004; Sekscenski et al., 1994; Weissert, 1996).
- Innovations in care delivery are stifled, especially in community settings that emphasize primary care, as well as in home or institutional settings for patients with chronic conditions.

- The cost of care is increased and much time is wasted by unnecessary physician supervision, and by duplication of services resulting from required “confirming” visits with a physician and co-signatures for prescriptions or orders.
- Educational and training functions and opportunities are distorted by disparate reimbursement eligibility for supervision of medical residents or students, on the one hand, and APN students on the other.
- Flexibility in deployment, both between and within existing delivery systems, is unnecessarily reduced.
- The risk of disciplinary action looms over even routine provider–patient interactions (such as a telephone consultation or filling a prescription) when these activities cross state borders.
- Millions of dollars and countless hours are spent in state and federal legislative and administrative proceedings focused on restricting or expanding scopes of practice or payment policies.
- The promise of new technologies and practice modes remains significantly unrealized. Telepractice or telehealth systems, for example, would allow APNs and other providers to utilize telecommunications technology to monitor, diagnose, and treat patients at distant sites, but their use is stymied by multiple and conflicting licensure laws and payment provisions.

Current Impediments to Removal of These Restrictive Provisions

The principal causes of the existence and continuation of unnecessarily restrictive practice conditions for APNs can be grouped into three categories: (1) purposeful or inertial retention of the dysfunctions resulting from the historical evolution of our state-based licensure scheme, (2) lack of awareness of APNs’ roles and abilities, and (3) organized medicine’s continued opposition to expanding the authority of other providers to practice and be paid directly for their services. All of these causes are rooted in the historical evolution of the state-based licensure scheme. The relevance of that history to the current regulatory environment can scarcely be overstated, and it is there that we must begin if we are to understand the present situation.

State-based Licensure and the All-Encompassing Medical Practice Acts

Historical development The United States was one of the first countries to regulate health care providers, and physicians were the first practitioners to gain legislative recognition of their practice. By the early 20th century, each state had adopted a so-called “medical practice act” that essentially claimed the entire human condition as the exclusive province of medicine. The statutory definitions of physicians’ scope of practice were—and remain—extremely broad. The following medical practice act is representative.

Definition of practice of medicine—A person is practicing medicine if he does one or more of the following:

1. Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
2. Administers or prescribes drugs or medicinal preparations to be used by any other person;
3. Severs or penetrates the tissues of human beings.⁶

The breadth of definitions such as this was remarkable in itself, but the real mischief was accomplished through corresponding provisions making it illegal for anyone not licensed as a physician to undertake any of the acts included in the definition. The claim staked by medicine was thereby rendered not only universal but (in medicine's own view) exclusive,⁷ a preemption of the field that was further codified when physicians obtained statutory authority to control the activities of other health care providers "so as to limit what they could do and to supervise or direct their activities" (Freidson, 1970). Not that long ago, for example, even registered professional nurses could not perform such basic tasks as taking blood pressure, starting an IV, or drawing blood unless under a physician's "order." Absent such a directive, they would have been deemed to be practicing medicine by "diagnosing" or "penetrating the tissues of human beings." (The full reach of the latter provision is further illustrated by the fact that, well into the 1970s, only physicians were permitted to pierce ears.)

Present-day consequences: competence, authority, and the disjunction between "can" and "may" Even though some of the more striking manifestations of this "everything is medicine" approach have gone by the wayside, the authority to supervise or direct other providers, combined with the authority to "delegate" medical procedures and tasks to nonphysicians, persists to this day. It underpins the legislative infrastructure that continues to subvert even the best efforts to develop a rational, effective scheme that promotes the highest and best use of all trained providers, especially those—like APNs—who seek to practice to the full extent of their competencies. No matter what their training, experience, and abilities, as noted earlier, they are perpetually in the position of having to carve out tasks or functions from the all-encompassing medical scope of practice that still prevails in every state. And even after the carving out has been accomplished, it is often accompanied by mandatory physician supervision or collaboration. In this way, the pervasive medical practice acts "exert a gravitational force that

⁶ *Rev. Code Washington* §18.71.011 (1)-(3) (1993).

⁷ Sociologist Eliot Freidson has aptly characterized this statutory preemption as "the exclusive right to practice" (Freidson, 1970).

continues to skew all attempts to rationalize the scopes of practice, or spheres of lawful activity, for providers other than physicians” (Safriet, 2002).

To be clear, the medical practice acts of every state authorize a licensed medical doctor to undertake virtually any kind of medical or health intervention. Indeed, by virtue of his General Undifferentiated Medical Practice authority (referred to by the profession itself as GUMP), “an MD may practice gynecology, oncology, orthopedics, pediatrics, retinal surgery, or psychiatry on alternating days, through treatment modalities that are decades old or were invented yesterday—all under the same generic medical license he obtained years ago” (Safriet, 2002, p. 311). Most physicians, of course, would never think of practicing beyond the bounds of their competence, but the point cannot be overstressed that it is not the licensure laws that prevent them from doing so. Rather, they limit their areas of practice according to norms deriving from common sense and decency, professional ethics and judgment, institutional credentialing and voluntary accreditation standards, and insurance concerns. That is, as individuals they implicitly acknowledge that their authority extends beyond the reach of their competence: They *may* do much more than they *can* competently do. And as they acquire new knowledge and skills, they may deploy them freely under their existing practice acts. Their existing authority, that is, covers any expansion of their competence.

Most APNs, in contrast, are in precisely the opposite situation. Thanks to the carving-out process that gave birth to their practice acts, their scopes of practice are so circumscribed that their competence extends far beyond their authority. They *can* do much more than they *may* legally do. In addition, they must seek administrative or statutory revision of their defined scopes of practice (a costly and often perilous enterprise) every time they acquire a new skill set. As a result, their competence—what they can do—is sometimes several years (or more) ahead of what they may do under existing law. The sum total of wasted professional assets represented by this disparity is striking.

The damage caused by the dynamic I have described is troubling enough when viewed from the perspective of a single jurisdiction, but it wreaks havoc on a national scale. Why? Because in each state the scopes of practice governing all health care providers (other than physicians) are the end product of a set of political realities, struggles, and compromises particular to that state. Stitched together, these practice acts become a crazy quilt of widely varied, often inconsistent, sometimes contradictory licensure and payment laws.

Although I have made the point already, it bears repeating: the crazy quilt makes no logical sense. Neither the underlying science of health care nor the capabilities of individuals change according to political boundaries. Bodies are bodies, and competence is competence, in both State A and State B. The only thing that changes at the border is the authority conferred or withheld by each jurisdiction. Indeed, the success of APNs and other providers in providing safe and effective care in State A and its progressive ilk—states where their authority has been enlarged in keeping with their competence—is the best possible evidence

that the constraints imposed by more restrictive jurisdictions are irrational. As one national organization has noted, “no study has shown that a state with restrictive scope of practice laws has better health outcomes than a state with expansive practice acts” (AAHC, 2008, p. 24).

Rather, the more restrictive jurisdictions embody the confluence of history, legislative realities, and the continuing professional dominance of the first organized group to arrive on the scene. Indeed, the point was neatly (if inadvertently) made by the Louisiana State Board of Medical Examiners in the pain-management Statement of Position referred to in the Introduction:

The Board’s opinion is not and cannot be altered by representations that a particular CRNA [Certified Registered Nurse Anesthetist] has received postdoctoral training in such areas or has performed such activities in this or another state. *A non-physician may have education, training, and, indeed, expertise in such an area but expertise cannot, in and of itself, supply authority under law to practice medicine* (emphasis added).

In offering the above summary, I want to be clear that I mean to attribute no malice or ill will to individual actors in the scope-of-practice battles. The problems have become structural and cultural, and we all—physicians included—pay a huge price for the consequences, measured in extra real dollars spent on health care, in lack of access to competent care, and in the constant antagonism among health care professionals who would be better served by working cooperatively to provide optimal care. Indeed, one of the saddest consequences of the dynamic I have described is that, in fighting the dominance of medicine, the other health care professions have fallen into some of the same patterns of asserted ownership and control. Physical therapists vie with occupational therapists, for example, about who may treat what, and clinical psychologists are often at loggerheads with professional therapists. Even worse, intraprofessional rivalries have begun to emerge: practitioners with more formal training seek to raise the ceiling for themselves while simultaneously struggling to make sure that their floor remains where it is, i.e., to make sure that no one with less extensive training will be permitted to perform certain contested tasks, regardless of their ability. There is a terrible irony in this “each against all” state of affairs, but it is the logical end product of a process that metes out authority based upon who one is, rather than what one can do.⁸

⁸ Interestingly, when it comes to physicians’ (rather than all other providers’) practice, recognition of shared ability seems to trump professional status. For example, with increased medical specialization and heightened reliance on specialty “certification” as a prerequisite for institutional privileges/credentialing as well as for payment eligibility, medical organizations themselves have begun to emphasize that a physician’s ability, rather than professional certification or specialty status, should determine scope of practice, at least as far as physicians’ clinical privileges are concerned. See, for example, the following from a listing of the American Academy of Family Physicians’ policy state-

General Public Lack of Awareness

Another result of the history deriving from our all-encompassing medical practice acts is the fact that the general public almost reflexively associates health care with physicians. Although nursing functions have existed for millennia, the formal development and legal recognition of APNs as a distinct professional group has occurred only in the past 40–50 years. Thus, though the public is increasingly familiar with provider titles such as nurse practitioner, nurse-midwife and nurse anesthetist, it is still “doctor” who “knows best.” As the prominent medical sociologist Eliot Freidson has noted, “health services” as understood in the United States “are organized around professional authority, and their basic structure is constituted by the dominance of a single profession [medicine] over a variety of other, subordinate occupations.”⁹ This construct, which underpins the continued centrality of “doctor” and “physician” in the popular culture, prevents the public from forming an accurate perception of the many and diverse types of essential health care providers and their spheres of competence. Instead, misperceptions are reinforced by mass media marketing messages—for example, those declaring that “only your doctor can prescribe” a drug, when, in fact, APNs in a majority of the states can and do legally prescribe that drug on their own license. Of course, this misperception is both the result of, and sustained by, laws that require a physician’s name to be listed on the label for a prescription written by an APN, or require a bill for APN services to be submitted in the physician’s name.

Of the three impediments to reform that I have identified, this lack of understanding on the part of the general public is clearly the most amorphous. It is a

ments on “Family Physicians Scope of Practice”:

“It is the position of the American Academy of Family Physicians (AAFP) that clinical privileges should be based on the individual physician’s documented training and/or experience, demonstrated abilities and current competence, and not on the physician’s specialty” (AAFP, 2010).

The American Medical Association (AMA) holds a similar position. Regarding clinical privileges, the 1998 AMA Policy Compendium states, “The accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant’s education, training and experience, and demonstrated current competence.” It also states that “[i]n implementing these criteria, each facility should formulate and apply reasonable non-discriminatory standards for the evaluation of an applicant’s credentials, free of anti-competitive intent or purpose” (AMA, 1998).

“AAFP strongly believes that all medical staff members should realize that there is overlap between specialties and that no one department has exclusive ‘rights’ to privileges” (AAFP, 2010).

⁹ He goes on to add that “[this] professional dominance is the analytical key to the present inadequacy of the health services.” Eliot Freidson, *Professional Dominance: the Social Structure of Medical Care* (1970). For an especially insightful analysis of the development of the cultural, economic, political, and social authority and dominance of the physician, and especially of organized medicine, see Starr (1982).

powerful part of the overall dynamic, however, because patients and their families cannot demand access to, and payment for, APNs' services if they are unaware of the availability and effectiveness of those services. Significant advocacy for more rational regulation will not emerge on a broad scale until laypeople understand what is possible, and what is at stake.

Legislative Inertia, "Scope of Practice Fatigue," and Organized Opposition to Change

Many states have recognized the evolution of APNs' education and training, as well as their documented practice abilities. In those states, APNs' licensure laws have been reformed in two important ways: first, they have been revised to eliminate requirements that APNs enter into formalized practice relationships with physicians (including practice agreements or protocols and physician supervision or direction); second, they explicitly grant APNs the authority to prescribe drugs and devices, to order and interpret tests, to admit to appropriate institutional facilities, and to be designated as primary care providers for various insurance programs—all on their own license as regulated by the Board of Nursing.¹⁰ In undertaking such reforms, these states have shaken off the detrimental effects of the medical-preemption dynamic described above. Instead, they have based their scope of practice and corollary provisions on assessments of these providers' proven clinical abilities, to the ultimate benefit of their citizens' health and pocket-books. Which raises the question: why have all states not done this, especially when faced with the growing, and increasingly expensive, health needs of the general public? There may be multiple reasons for this, but three are especially noteworthy.

Legislative inertia and scope of practice fatigue To begin with, the legislative process writ large is generally characterized by inertia. Change requires not only the identification and analysis of problems and potential solutions, but, even more importantly in the political arena, a coalescence of support sufficient to enact a measure. Given the usual context within legislators must act—a context reflecting multiple agendas and interests, as well as finite political or suasion capital—it is often easier to “let things be” than to marshal the forces required for change.

This dynamic is compounded, in the case of licensure practice act proposals, by “scope of practice fatigue.” Most legislators are well acquainted with (and many have been caught in the crossfire of) the professional “turf battles” that have played out repeatedly across the states as individual provider groups seek modifications to their professional practice acts or administrative rules to better

¹⁰For a comprehensive review of each state's regulations, see Pearson (2009).

reflect their evolving competencies (Finocchio et al., 1998, p. 50).¹¹ Understandably, lawmakers have grown weary of the fight, especially when there may be little to gain and much to lose in championing reform.

Organized opposition to change These two factors—legislative inertia compounded by weariness and risk-aversion—define the arena within which a more active and powerful force has been brought to bear, and that is the advocacy efforts of several national medical organizations and their state affiliates.

Countless thousands of individual physicians (including two who helped create the new roles of nurse practitioner and nurse anesthetist) have long recognized and supported the full practice capabilities of APNs. It is the official policy of several national medical organizations, however, to actively oppose legal recognition of any other providers' expanded authority to practice without physician supervision and be paid directly for their services.

Seemingly unmoved by the demonstrably safe and effective practice of unsupervised and directly paid APNs in many states, organizations such as the American Medical Association, the American Society of Anesthesiologists, and the American Academy of Pediatrics continue to oppose rational realignment of APNs' state practice authority and eligibility for reimbursement. The following sampling of policies, and public statements by their officers, is illustrative.

- The American Medical Association has adopted and continued to reaffirm resolutions which direct the organization to pursue, “through all appropriate legislative and other advocacy activities,”¹² measures designed to
 - “oppose the enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirement for medical licensure,”¹³ (a position that may seem unremarkable until one remembers that, under the medical practice acts, everything is “the practice of medicine”);
 - “oppose any attempt at empowering non-physicians to become unsupervised primary medical care providers and be directly reimbursed”,¹⁴ and
 - support physicians who oppose efforts by alternative providers to obtain increased medical control of patients by legislatively expanding

¹¹ Finocchio et al., 1998, hereinafter, the Taskforce Report. Others have characterized these considerations as “scope-of-practice firefights” and “akin to war.” Jay Greene, *Physician Groups Brace for Allied IncurSION*, Am. Med. News, Dec. 11, 2000, at 1; LaCrisha Buttle, *Nonphysicians Gain Clout*, Am. Med. News, Jan. 17, 2000, at 1, 26.

¹² Am. Med. Ass'n, H.D. Res. H-360.988 (2000).

¹³ Am. Med. Ass'n, H.D. Res. H-35.988 (1982).

¹⁴ Am. Med. Ass'n, *Independent Nursing Practice Models*, Proceedings of the House of Delegates 141, 152 (1990).

their scopes of practice without physician direction and oversight by state boards of medical examiners.¹⁵

- The policy statements of the American Society of Anesthesiologists include the following:
 - “ASA opposes the independent practice of nurse anesthetists and views legislation and regulations designed to grant independent practice authority—mostly regulations promulgated by state nursing boards without concurrence by state medical boards—as efforts to confer a medical degree by political means rather than by educational means” (ASA, 2004, p. 4).
 - “Anesthesiology, in all of its forms, including regional anesthesia, is the practice of medicine” (ASA, 2004, p. 24).
- From the American Academy of Pediatrics:
 - “AAP chapters and state medical and specialty societies, as well as national medical and specialty societies, should be proactive in legislative advocacy and should partner in informing legislators, health care purchasers, the media, and the public about the differences in the education, skills, and knowledge of various health care professionals. Legislative advocacy includes opposing legislation to expand the scope of practice of nonphysician clinicians, particularly independent practice, independent prescriptive authority, and reimbursement parity” (AAP Committee on Pediatric Workforce, 2003—reaffirmed January 2006).
 - “A public conflict with nurse practitioners who have independent practice status in some states, could endanger hopes for health care reform that could be very beneficial to pediatricians . . . We don’t want to hurt the efforts of our members to preserve physician-directed primary care [and] we encourage our members to oppose scope of practice legislation’ that would permit nurse practitioners to have independent practices” (Anderson, 2009).¹⁶

Although this opposition¹⁷ could be motivated by several factors, a consistent theme seems to be that “if something is medicine”—and of course everything is,

¹⁵ See Am. Med. Ass’n, H.D. Res. H-160.947 (2000).

¹⁶ David Tayloe, Jr., President of the American Academy of Pediatrics, commenting upon the eligibility of Nurse Practitioners to participate in health/medical homes pilot projects.

¹⁷ In furtherance of its long-standing opposition to APN independent practice (including prescribing authority) and direct payment, the AMA, in concert with six national medical specialty societies and several state medical associations, formed a coalition named the Scope of Practice Partnership (SOPP) in 2005. The express purpose of the SOPP is to “concentrate the resources of organized medicine to oppose scope of practice expansions by allied [sic] health professionals that threaten the health and safety of the public.” See AMA Board of Trustees Report 24—A-06, Subject: Limited Licensure Health Care Provider Training and Certification Standards (2006).

given the breadth of the definition in state medical practice acts—then it cannot be a skill or task that can be competently (or legally) performed independently by anyone other than a medical doctor. As I have noted elsewhere (Safriet, 2002, p. 310), such an approach reflects a profound misapprehension of the dynamic nature of knowledge and skill acquisition, and it stands in stark contrast to a more realistic notion of shared versus exclusive prerogatives.¹⁸

The pervasiveness of this perspective of professional exclusivity is exemplified by its incorporation, perhaps unwittingly, in an otherwise helpful informational guide on scope of practice that was developed by the Federation of State Medical Boards, a national nonprofit organization representing the 70 medical boards of the United States and its territories (FSMB, 2005). Two aspects of the FSMB Guidelines are especially noteworthy. First, they are intended to be considered “by State medical boards and legislative bodies when addressing scope of practice initiatives relating to persons *without a license to practice medicine*”¹⁹—in other words, to everyone other than physicians, whose scope of practice is seemingly assumed to be not only universal but inviolable and eternal. Second, the underlying assumption of the preeminence of medicine is made explicit by the prefatory statement that “All discussions about changes in scope of practice *should begin with a basic understanding of the definition of the practice of medicine* and recognition that the education received by physicians differs in scope and duration from other health care professionals. Non-physician practitioners may seek authorization to provide *services that are included in the definition of the practice of medicine* under existing state law” [emphases added].²⁰ Statements like these seem to reify the primacy and exclusivity of medicine. They ignore the reality that competencies are shared, and that legal authorization of these competencies could and logically should be based on professional abilities rather than notions of exclusive ownership.

While this “everything begins with medicine” trope continues to animate the advocacy activities of some, others have pursued a very different approach to rationalizing the authority–abilities metric that should guide regulatory practice parameters for all health care providers. The most succinct statement of this approach is set out in a 2007 monograph entitled *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations*, collaboratively produced by

¹⁸ See, for example, Mirvis (1993): “[N]urses, clinical pharmacists, and other allied health professionals are now educated and trained to perform many tasks previously assigned only to physicians. In these areas, physicians have a right to *autonomy* because of their knowledge, but it is *not an exclusive right*. Instead, it is a right to be *shared* with other appropriately credentialed professions [emphasis added].”

¹⁹ FSMB Guidelines, p. 1. (emphasis added).

²⁰ Ibid.

representatives of six associations of regulatory boards (NCSBN, 2007).²¹ The monograph emphasizes that the most important—indeed the only relevant—questions concerning scope of practice are whether the “change will better protect the public and enhance consumers’ access to competent healthcare services.” In contrast to the static, exclusivity paradigm adhered to by some, the monograph notes two particularly relevant basic assumptions that should frame any scope-of-practice decision:

- **“Changes in scope of practice are inherent in our current health-care system.** Healthcare and its delivery are necessarily evolving. . . . Healthcare practice acts need to evolve as healthcare demands and capabilities change.”
- **“Overlap among professions is necessary.** No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession’s skill set does not mean another profession cannot and should not include it in its own scope of practice.”²²

It is to be hoped that this “safe and effective abilities” focus will supplant the “first we must start with medicine” refrain as legislative and administrative actions to foster less restrictive practice parameters for all providers are undertaken at both state and federal levels. If so, we will move closer to the goal of enhancing the public’s access to practitioners who can provide competent and cost-effective care in a wide range of practice settings.

THE GROWING RECOGNITION OF THE NEED FOR CHANGE

While professional associations, legislators, and administrators are all too familiar with the difficulties encountered in reconciling regulatory authority with evolving clinical abilities, an awareness of the need for change has been slow to develop in the wider policy-making and public arenas. Now, however, with sustained efforts to increase access to care in cost-effective ways, a growing and increasingly diverse chorus of voices is calling for true reform of health care workforce regulations.

²¹ The Monograph was developed by representatives of the following organizations: Association of Social Work Boards (ASWB), Federation of State Boards of Physical Therapy (FSBPT), Federation of State Medical Boards (FSMB), National Board for Certification in Occupational Therapy (NBCOT), National Council of State Boards of Nursing (NCSBN), and National Association of Boards of Pharmacy (NABP). Full text of the document: <https://www.ncsbn.org/ScopeofPractice.pdf>.

²² Monograph, p. 9.

Early Studies: The Pew Commission and Institute of Medicine Reports

One of the earliest and most thorough analyses of the regulatory context of health care providers was produced in 1998 by the Pew Commission's Taskforce on Health Care Workforce Regulation (Finocchio et al., 1998). The Taskforce Report looked broadly at professional regulatory components, including boards and governance structures as well as continuing competence requirements, and more particularly at scopes of practice authority. Noting that "differences from state to state in practice acts for the health professions no longer make sense," the Taskforce recommended the development of national standards for uniform practice authority, and the dissemination to the states of models based on "the least restrictive practice acts for each profession." Among their findings and recommendations are the following:

- "Traditional boundaries—in the form of legal scopes of practice—have blurred."
- "Some scopes of practice conferred upon licensed occupations and professions are unnecessarily monopolistic, thereby restricting consumers' access to qualified practitioners and increasing the costs of services."
- "Clinical practice is no longer based on exclusive professional or occupational domains."
- "If someone is competent to provide a health service safely, and has met established standards, then he or she should be allowed to provide that care and be reimbursed for it, even if that care was historically delivered by members of another profession."
- "Demonstration projects [can] provide an empirical basis for rational development of legally defined scope of practice provisions, which reflect evolving clinical competence, and make optimum use of skilled health care practitioners."

Several years later, the lessons of the Report's scope-of-practice analysis were reflected in the 2001 Institute of Medicine publication *Crossing the Quality Chasm* (IOM, 2001), which noted that "a major challenge in transitioning to the health care system of the 21st century envisioned by the committee is preparing the workforce to acquire new skills and adopt new ways of relating to patients and each other." Among the approaches recommended by the IOM Committee was a modification of "the ways in which health professionals are regulated to facilitate the needed changes in care delivery. Scope-of-practice acts and other workforce regulations need to allow for innovation in the use of all types of clinicians to meet patient needs in the most effective and efficient way possible." This approach led to the recommendation that research be pursued "to evaluate how the current regulatory and legal systems . . . facilitate or inhibit the changes needed for the 21st-century health care delivery system."

The Emerging Consensus

More recently, several reports by research organizations, as well as statements by health policy analysts, have focused on the need for reform of the regulations affecting both practice boundaries and payment for providers such as APNs. A short summary of these commentaries further confirms that the views of health care analysts are converging on a central conclusion: the current scope-of-practice framework must be changed.

- In cautioning against the “Siren Song of GME [Graduate Medical Education]” expansion as a means of addressing the need for more primary care services, Fitzhugh Mullan and Elizabeth Wiley note: “The increased need for physician services can be met by better use of the physicians we have now . . . and by the increased use of nurse practitioners and physicians assistants in primary care and specialty care settings. The *important principle* underlying this latter strategy is that *all clinicians should work to the maximum of their training and licensure* [emphasis added]” (Health Affairs, 2009).
- In identifying necessary foundations for cost containment and value-based care, the Engelberg Center at Brookings included as a key reform for improvement of the health care workforce: “*Create incentives for states to amend the scope of practice laws to allow for greater use of nurse practitioners, pharmacists, physician assistants, and community health workers* [emphasis added]” (Engelberg Center for Health Care Reform at Brookings, 2009, p. 2).
- In a report for the Business Roundtable evaluating the effects of health care reform through the lens of the private sector, Hewitt Associates recommended that, as part of the concept proposed in some current reform bills to create an Innovation Center at the Centers for Medicare and Medicaid, test models should include measures to fund “nurse-practitioners and physician assistants to manage chronically ill patients,” and to enhance greater professional service capacity by “greater utilization of nurse practitioners” (Hewitt Associates, 2009, pp. 8, 22).
- In a comprehensive analysis of the need for a national, coordinated health workforce policy, the Association of Academic Health Centers found that “*Inconsistencies in scope of practice laws engender numerous challenges.*” The report went on to add that “*lack of national uniformity in scope of practice limits health professionals’ mobility and practice,*” and that “many professionals and policymakers believe that the appropriate response to workforce shortages is to *expand the scope of practice of various health professionals.* Such a change would also contribute to leveraging workforce capacity and increase access to care.” Unless and until this is done, “patients may be unable to obtain the services of skilled

- providers across state lines and may have fewer choices of safe and effective providers [emphasis added]” (AAHC, 2008, pp. 21, 26, 27).
- A National Association of Community Health Centers report on transforming primary care services noted that “NPs and PAs play a vital role in the delivery of primary care. *State scope of practice laws, which regulate the range of permissible practice for various health care professionals, encourage NPs to locate in states allowing them to provide a broader range of services.*” The report added that “State scope of practice standards set the boundaries by which key primary care providers, namely NPs and PAs, can deliver care. *State policymakers must consider how these standards encourage or discourage primary care professionals to locate in and form teams in underserved areas.* Some states, including Colorado and Pennsylvania, have dealt with primary care shortages in underserved areas by expanding scope of practice for NPs, PAs, CNMs, nurses, and dental hygienists. If health centers are to form medical or health care homes and maximize quality and efficiency, policies that facilitate team functions for patients will be needed [emphasis added]” (NACHC, 2009).
 - An analysis by the National Academy of State Health Policy of state regulations governing retail clinics concluded that such clinics are a desirable service-delivery mechanism providing accessible, less costly, evidence-based services. The analysis went on to note that, as reported by clinic representatives, the “most powerful state *regulatory tools affecting their operations are the scope of practice regulations that govern nurse practitioners and [physician assistants].*” “These kinds of regulations can greatly affect the cost structure of retail clinics and may affect where retail clinics locate, their staffing, and their hours of operation.” The report concluded that many states have chosen not to regulate these clinics directly, but rather have relied on existing health care provider regulations and market forces to decide the fate of these clinics, with one ‘most notable exception’: “*often in response to physician groups, states have increased physician oversight of non-physician practitioners who work at retail clinics [emphasis added]*” (NASHP, 2009).

Pulling It All Together: The RAND Corporation Study

All of these themes are echoed and elaborated in one of the most recent and comprehensive reports in the field, which focused specifically on the access, quality and cost gains to be realized by reforming the current regulatory mélange. The Massachusetts Division of Health Care Finance and Policy commissioned the RAND Corporation to “develop a comprehensive menu and assessment of cost containment strategies and options and to determine their potential effect on the health care system.” The resulting report released in August 2009 (Eiber et

al., 2009) described the results of analysts' assessment of 12 high-priority policy options, including upper- and lower-bound estimates of potential cost savings from these options over 10 years.²³ In addition, the report identified "what has to happen to implement a change" for each of the options. Under the general heading of "Redesign[ing] the Healthcare Delivery System," the most promising cost containment options included two²⁴ of particular relevance to APNs—"Encourag[ing] Greater Use of Nurse Practitioners and Physician Assistants," and "Promot[ing] the Growth of Retail Clinics."²⁵ (These options are significant, for purposes of this paper, because nurse practitioners [NPs] are a major cohort within the larger class of APNs, and the analysis that applies to them applies also to their other advanced-practice colleagues.) The most relevant passages of this section of the report are quoted below.

*Option: Encourage Greater Use of Nurse Practitioners...*²⁶

Nature of the Problem

Even though they are educated to perform many routine aspects of primary and specialty care and even though studies have shown that they provide care similar to that provided by physicians, NPs generally cannot practice as independent medical providers and therefore are underutilized in the provision of primary care.... Given widespread agreement that there is a critical shortage of primary care physicians in the Commonwealth, expanding scope-of-practice laws could be a viable mechanism for increasing primary care capacity and reducing health care costs.

Proposed Policy Option

Under a changed [more independent] scope of practice, public and private insurers could choose to reimburse NPs directly for their services and could allow consumers to choose a non-physician provider as their primary care [provider]. Specifically,

- Allow NPs to practice independently, without physician oversight.
- Allow greater practice autonomy for NPs by eliminating the requirement that the Board of Registration in Nursing consult and reach consensus with the Board of Registration in Medicine to promulgate its APN regulations.

²³ For a summary of results of further modeling of eight of the original policy options on a national scale, see Hussey et al. (2009).

²⁴ A third option relevant to ANPs, Create Medical Homes, is not included here since the modeled analysis was limited specifically to "physician-led teams," and some current reform proposals include a broader definition of primary care provider-led health homes which could be led by APNs.

²⁵ This latter option is important because retail clinics are staffed principally by nurse practitioners.

²⁶ Although the RAND report included PAs and NPs in this policy option, I have omitted references to PAs from this summary, both because my focus is on APNs, and because the regulatory scheme for PAs is fundamentally different than that for APNs, in that, though individually licensed, their scope of practice in all states is determined by delegation by a required supervising physician.

- Reimburse NPs directly for their services. Since NPs [currently] cannot bill directly for their services, bills presented to insurers often are not transparent and may not even indicate who provided the treatment. Were the state to allow nonphysician providers to practice independently, and therefore bill directly for their services, payers would have the option to pay differential rates for primary care services.
- Allow consumers to designate an NP as their primary care provider. This was accomplished, pursuant to a new cost containment law, which requires all insurance carriers to provide members the opportunity, on a non-discriminatory basis, to select a NP as a primary care provider.
- Use provider payment options (such as capitation and case rates) that would encourage physicians to utilize NPs. Providers or provider organizations that accept risk (such as in capitation or case rate payment) will have an economic incentive to employ NPs, whereas those paid on a fee-for-service basis may not. As observed by the Pew Commission, ‘The cost-saving imperatives explicit in capitation will move service-delivery to the least costly practitioners. Moreover, third-party payers likely will focus more on services than on providers in determining reimbursement.’
- Reimburse the same amount for basic medical services, whether provided by a physician or an NP.

It should be emphasized that, in framing their cost analysis, the report’s authors used quite conservative treatment assumptions. For the lower bound of savings, they assumed that “NPs and PAs could provide all care for 6 simple acute conditions (cough, throat symptoms, fever, earache, skin rash, and nasal congestions), corresponding to the subset of conditions commonly treated at retail clinics.” For the upper bound of savings, they assumed that these providers could provide care for these six conditions “as well as for all general medical examinations and well-baby visits.” Even given these narrow treatment parameters, the potential savings in Massachusetts over a 10-year period ranged from a lower bound of \$4.2 billion to an upper bound of \$8.4 billion.

The authors also noted that the higher savings estimates were supported by a majority of the studies in the research literature, which confirm that NPs and PAs “can deliver care for a large fraction of diagnoses at equivalent quality and lower cost than physicians,” that the “use of NPs leads to high levels of patient satisfaction,” and that “NPs are more likely to provide disease prevention counseling, health education, and health promotion activities than are physicians.”

Quite tellingly, the factors that were identified as tending toward the lower savings range involved some of the common regulatory dysfunctions discussed earlier in this paper. First and foremost was the challenge presented by the need for revised laws broadening the scope of practice of NPs (and, by implication, other APNs as well): “Proposed changes in scope-of-practice laws are ‘among the most highly charged policy issues facing state legislators and health care regulators,’ often triggering guild or ‘turf battles among professions’ that have

at times lasted over a period of years.” In addition, the report noted that the restrictive nature of Massachusetts’s practice parameters may have reduced the supply of NPs available to practice in that state, even if its licensure laws were to be reformed, because many may already have left the state or dropped out of the workforce. “[R]esearch suggests that the supply of NPs is influenced both by scope of practice and reimbursement policies, and that a greater supply is available in states with more expansive scope of practice regulations.”

The detailed analysis contained in the RAND report confirms and amplifies the fundamental conclusion reached by an ever-growing cohort of health care policy analysts: many of the most promising efforts to improve our health care delivery system will have to reckon with the debilitating regulatory restrictions currently imposed on providers’ practice parameters. While a fundamental restructuring of these laws may be long in coming, there are many steps that can be taken now to address some of the well-known, pervasive problems.

STRATEGIES FOR CHANGE AT THE FEDERAL LEVEL

There is a broad range (in both scope and number) of actions that the federal government could undertake to eliminate, or at least ameliorate, the adverse effects of the many impediments noted above. Some of these actions emphasize uniform national practice standards and parameters, and are therefore perhaps more aspirational in nature. Others are more specific and immediately actionable. Of the latter, some have to do with the federal government’s own policies and agencies, and others are measures that the federal government could take to promote rational policymaking in the states.

The Aspirational: What Would an Ideal System Look Like?

Rationalizing Education, Licensure, and Compensation

If one were charged with the task of designing a logical and effective educational and regulatory framework for the health care workforce, it seems clear that the resulting scheme would include few if any of the most notable features of our current system. It would not, for example, segregate students into profession-specific introductory courses in biology, anatomy, physiology, chemistry, and the like. It also would not presume that all aspects of the healing arts and sciences are within the ambit of any, or surely only one, profession. And given the universal, scientific nature of human physical and mental health, it would not tolerate 50 or more variations in each of the practice parameters for each of the many professional roles, all developed through the lobbying of elected politicians by special interest groups. Finally, it would not pay for services at a rate based entirely upon the licensed status of the provider. In short, it would not replicate the educational, practice, and payment provisions of our current system.

Rather, the ideal framework would do the following:

- provide for a common curriculum for all health professional students for foundational courses, and include requirements for interdisciplinary training in clinical practice settings;
- recognize that the provision of health care entails a range of actions, and regulate those actions based upon the degree of danger and specialized skill involved;
- explicitly acknowledge, for tasks that should be regulated, that the competence to perform these tasks safely is not profession-specific;
- establish appropriately uniform professional standards and practice parameters;
- accommodate needed flexibility and evolution in a profession's practice by utilizing assessment processes in which an appointed, standing committee would review proposals for change and make recommendations for necessary governmental action; and
- base payment for covered services on what and how well a service was provided, rather than on who provided it.

The Federal Role in an Ideal Scheme

The logical consequence of such an approach would be national regulations (including federal licensure or certification, as appropriate) for all regulated health providers, with more uniform educational preparation and scope-of-practice provisions for each profession. A variation on this scheme could be what one might call “shared direct licensure,” in which the federal government would establish a uniform scope of practice for each profession, while retaining the current role of state licensure boards in performing credentials evaluation and verification, disciplinary functions and continued competence assessments.

A national approach to licensure (either comprehensive or shared with the states) is intuitively appealing. After all, the healing arts, as applied, are organic rather than political or geographic, and there are already many national characteristics and requirements embedded in current systems governing educational accreditation, licensure examinations, and professional certification. Unfortunately, notwithstanding the benefits of such an approach, there are undeniably many obstacles to its implementation. Two in particular stand out: (1) the realities of the traditional (though not inevitable) role of the states in health care licensure; and (2) the likelihood that the very same forces that have prevailed in many states would succeed in bringing about a similar result at the national level—that is, in making sure that national standards would embody the most restrictive, rather than the most progressive and empowering, scope-of-practice provisions, thus actually making the situation worse in those states that currently pursue a more enlightened approach.

The Here-and-Now: What Immediate Steps Can the Federal Government Take to Promote the Highest and Best Use of APNs?

Given these and other realities, perhaps the preferred path for the federal government should be to pursue a more rational regulatory framework by (1) promoting best practices drawn from current domestic and international systems and (2) remedying specific problems that are within its power to resolve. There are a number of steps that could be taken now to advance this agenda.

Articulate National Priorities and Raise Public Awareness: the “Bully Pulpit”

National priorities Through an Executive Order or other appropriate vehicle, the federal government could declare that the highest and best utilization of health care providers is a national priority, consistent with the goal of promoting wider access to quality care in cost-effective ways. And unnecessary restrictions on providers’ practice scopes distort efficient practice and impede the development of more innovative and effective delivery mechanisms.

Public awareness By explicitly identifying the highest and best use of all providers as a national priority, the federal government would also begin to raise public awareness of APNs and other providers and what they can offer. A follow-on public information campaign could provide further detail.

Identify, Integrate, and Publicize Best Practices in a Preferred Scope of Practice Framework

Building on previous calls for federal action on workforce policies,²⁷ the administration (through the Secretary of HHS, the Surgeon General, or CMS) could appoint a Health Workforce Commission. The Commission would be charged with:

- gathering and analyzing the most progressive regulatory provisions to be found both domestically and internationally²⁸;
- producing a “preferred scope of practice framework” for APNs (or all health care providers) that incorporates the least restrictive conditions necessary for safe and effective practice; and

²⁷ See, for example, the Pew Taskforce, the IOM Report, and the AAHC reports.

²⁸ As I and others have noted elsewhere in some detail [see Safriet (2002) and Dower (2008)], many preferred practices could be drawn from the existing framework of the Ontario Regulated Health Professions Act. For a complete description of the evolution and current parameters of that scheme, see <http://www.hprac.org/en/>.

- distributing the model to
 - state and federal entities responsible for any facet of regulating health providers' practice or payment for services, and
 - private entities that utilize or pay for providers' services (such as commercial insurers and health care facilities), or which establish or review standards for institutional or organizational accreditation.

This strategy would promote wider awareness of both the problems of the current system and the existence of achievable, preferred practices.

Incentivize the States to Adopt the Preferred Framework

Raise awareness and promote rational analysis Pursuant to existing (or, if necessary, supplemental) statutory authority for annual state reports and assessments of Medicaid and SCHIP, the Secretary of HHS and/or the Administrator of CMS could require the Governor and/or Director of Medicaid/SCHIP of each state to submit an annual report that:

- specifies how any of their state's health care provider practice acts and regulations impose restrictions not included in the preferred model framework, and
- documents the justifications for these continued restrictions.

A compilation of these reports could be posted on the HHS and CMS and other appropriate websites and could be distributed to associations such as the National Council of State Legislatures and the National Governors' Association, as well as to public advocacy groups.

Create fiscal incentives A final step in this progression would move from increasing awareness of to incentivizing the adoption of the preferred framework. The Medicaid federal match formula could be increased by 0.5 percent for those states that revise their laws to be consistent with the preferred framework, or (perhaps more equitably for those states that have already reformed their laws) the federal match for nonconforming states could be decreased by 0.5 percent.

Ensure That APNs Are Visible, and That Their Roles Are Taken into Account

To ensure that APNs and nursing in general are "present and accounted for" when counting matters, at least two significant actions should be taken.

- The National Center for Health Statistics should confirm that all its National Health Surveys and resulting statistical and series reports include information on the full range of APNs' practices and settings.

- All federal agencies (CMS, NCHS, HRSA, etc.) should be charged with ensuring that any coding, assessment or benchmark schema used in any federal health care program (or state program receiving federal funds) for payment, performance, accreditation, or forecasting purposes are inclusive and fairly representative of the kinds of providers and practices affected by those schema. A partial list of such metrics would include the Medical Expenditure Panel Survey, HEDIS, CAHPS, CPT codes, performance measures and quality indicator data sets, Joint Commission and National Quality Forum standards, and benchmark tools for federally sponsored pilot and demonstration projects and the like.

Monitor for Anticompetitive Behavior

The Federal Trade Commission (FTC) should be charged with actively monitoring proposed state laws and regulations specifically applicable to retail or convenient care clinics (or other innovative delivery mechanisms utilizing APNs) to ensure that impermissible anti-competitive measures are not enacted. The need for such monitoring is confirmed by the recent FTC²⁹ evaluations of proposals in Massachusetts and Illinois and Kentucky, which revealed that several such provisions (including limitations on advertising, differential cost-sharing, more stringent physician supervision requirements, restrictions on clinic locations and physical configurations or proximity to other commercial ventures, and limitations on the scope of professional services that can be provided which do not apply to the same credentialed professionals in comparable limited care settings) could be considered anticompetitive.

Rationalize Professional Education and Training Opportunities and Corresponding Payment Schemes

Curriculum The Department of Education should emphasize interdisciplinary curricular opportunities in the criteria used by the National Advisory Committee on Institutional Quality and Integrity in granting continued recognition of nationally recognized accrediting agencies for health care education.

Graduate-level education for APNs Federal funding for graduate-level, APN education (and educational loan-repayment subsidies) should be expanded. Since the time and cost required for completing APN educational and training require-

²⁹ Letter from FTC Staff to Elain Nekritz, Illinois Legislature (May 29, 2008), available at <http://www.ftc.gov/os/2008/06/V080013letter.pdf>; Letter from FTC Staff to Massachusetts Department of Health (September 27, 2007), available at <http://www.ftc.gov/os/2007/10/v070015massclinic.pdf>. Letter from FTC Staff to Kentucky Cabinet for Health and Family Services (January 28, 2010), available at <http://www.ftc.gov/os/2010/02/100202kycomment.pdf>.

ments is less than that for comparable physician providers, some have estimated that an expenditure of \$1 billion (of either new funds or those shifted from GME) could lead to a cumulative 25 percent increase in the number of fully qualified APNs over a 10-year period.³⁰

The role of Medicaid and Medicare Medicaid regulations should be clarified to ensure that Nurse-Managed Health Centers and Clinics are eligible for Medicaid reimbursement.

Medicare reimbursement for hospitals should include payment for expanded APN training programs; similarly, reimbursement for APNs' supervision and training of medical students and residents as well as APN students in hospitals should be made on the same basis as that for physician supervisors.

Promote Parity in Recognition and Payment for Services

- Medicaid should require states to recognize nurse practitioners and certified nurse midwives as Medicaid Primary Care Case Managers, as opposed to the current provision for “optional” recognition.
- If an APN's services are allowed by state law to be provided autonomously without supervision by any other provider, CMS should not condition any designation (such as those required for “Centers of Excellence”) or Medicare or Medicaid coverage and payment for those services upon any required supervision. Among other provisions affecting APNs, this would require a revision of the current CMS “Opt-Out” regulation³¹ for conditions of participation for anesthesia services in hospitals, critical access hospitals, and ambulatory surgical centers. Under the current regulation, even in states whose licensure laws do not require physician supervision of certified registered nurse anesthetists, CMS will not pay for an “unsupervised” CRNA's fully competent and authorized services unless the Governor of that state, after conferring with the Boards of Nursing and Medicine, certifies to the CMS that s/he has found that “it is in the best interests of the state's citizens to opt-out of the current federal physician supervision requirements, and that the opt-out is consistent with state law.”
- CMS should encourage state Medicaid programs to cover health care services provided by retail or convenient care clinics.
- Consistent with the comprehensive primary care services they provide to uninsured and vulnerable populations, Nurse-Managed Health Centers

³⁰ Lewin Group, 2009 study.

³¹ 66 FR 56762, 11/13/2001, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=01-1388-filed.pdf. Currently, 15 states have “opted out” of these supervision requirements.

should be eligible for the same enhanced reimbursement and support provided by the government to Federally Qualified Health Centers.

Undertake Other Available Measures to Improve APNs' Practice Context

While I candidly acknowledge that I am not aware of all of the many authorization, payment, or even survey provisions contained in the hundreds of state and federal regulatory measures affecting APNs—and I am not sure that anyone could be—I do know that there are many examples of APNs' differential treatment or total absence. While policy makers and other public advocates move forward with efforts to remove many of the large-scale impediments resulting from the dynamics previously discussed, there are immediate steps that can be taken improve the practice context for APNs. Several specific examples follow:

- The CMS should ensure that APN practices, including Nurse-Managed Health Centers, are eligible to receive subsidies under the ARRA of 2009/stimulus funds for adoption of the Electronic Health Records systems currently being developed by the Health Information Technology Policy Committee, or any other HIT initiatives.
- The Office of Personnel Management should condition any insurer's participation in the Federal Employees Health Benefits Program upon verification that APNs' services (consistent with their full authority under state law) are directly accessible by members and are covered and paid for on the same basis as physicians.
- Any federally sponsored initiative to promote patient-centered, coordinated primary care should incorporate the Institute of Medicine's definition of primary care, which includes "the provision of integrated, accessible health care services by *clinicians* who are accountable . . . [emphasis added]" (IOM, 2001). Consistent with this, legislation and implementing rules should assure that any federal pilot or demonstration initiatives under Medicare or Medicaid promoting primary care (such as "health- or medical-homes") include APN-led practices and Nurse-Managed Health Clinics as eligible participants. Furthermore, CMS should encourage or require any accrediting organization (such as the National Committee on Quality Assurance) whose assessments and recognition are relied upon in any way for basic or enhanced reimbursement, to include APN-led practices in their health/medical home standards and processes.
- In Medicare legislation and CMS regulations, the terms "physician" and "physician services" should be defined to include APNs' services when those services are within the APNs' scope of practice as defined by state law.
- Medicare legislation and implementing regulations should authorize

nurse practitioners and certified nurse specialists to certify patients for home health services and for admission to hospice, and clarify that they are authorized to certify admission to a skilled nursing facility, and to perform the initial admitting assessment.

- Medicare Hospital Conditions of Participation should be amended or clarified to facilitate APNs' eligibility for clinical privileges and membership on the medical staff.
- Nurse-Managed Health Clinics should be included in the regulatory definition of "essential community providers" that will be promulgated pursuant to the section of the Affordable Care Act that creates the Health Benefit Exchanges.

CONCLUSION

Almost every aspect of health care in the United States is in flux. The current reform debates include a seemingly endless (and ever-changing) number of proposals intended to reduce costs and improve access to quality health services. At the same time, modes of health care delivery continue to evolve synergistically at a breathtaking pace, with newly discovered biologics and pharmaceuticals, increasingly adept robotic interventions, personalized therapeutics, nanotechnology, interactive knowledge platforms, and computerized diagnostic and treatment aids that reduce the barriers of time and geography.

The end product of these developments is unknown. Health care reform, even when finalized, will not be fully implemented for several years, and the resulting ramifications on the efficiency and effectiveness of the delivery system will not be understood until even later. And the science and technology of health care delivery will continue to evolve.

In contrast, there are certain fundamental things that we do know.

- The infrastructure necessary for the implementation of any conceivable reforms—and for the application of new assessment and treatment modalities—is deeply flawed, stuck in place and amazingly static.
- More specifically, the framework for certifying to the public that an individual trained to provide care can do so competently is profoundly broken for the reasons I have described.
- Notwithstanding the larger uncertainties, there are known problems with promising solutions which can be acted on immediately, and which will be helpful now and in the future regardless of the final contours of any reform legislation or further developments in the delivery of care.

In sum, the fundamental flaws in the regulatory framework that I have described are real, and they rob us as a nation of the full range of care options that our health care providers are capable of offering. This is particularly true of

APNs, who have a proven track record of providing needed care across a range of patient populations and practice settings—and this in spite of the regulatory obstacles with which they have had to contend. Freeing APNs from the unnecessary constraints I have identified (which are at bottom nothing more than the historical artifacts of medical preemption) will achieve two important objectives. First, it will better enable Americans, wherever they are situated, to receive much-needed health services at a cost they can afford. Second, it will begin to remedy the systemic unfairness that has distorted many aspects of the healthcare delivery system, and will serve as a model for comprehensive reform of our entire regulatory framework by focusing on the evolving ability and competence of all providers rather than on rigid proprietary prerogatives.

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