



**Medicaid Redesign Team
Workforce Flexibility / Scope of Practice Workgroup
Proposal Information Sheet**

Proposal Number and Short Name: 47

Identifying # from Spreadsheet:

Sector-(specify sector, e.g., acute care, LTC, etc.): Remove the requirement that certified Nurse Practitioners enter into a written collaborative practice agreement with a licensed physician (See A5308/S3289).

Proposal Author: Name/Organization/Contact Information: Joy Elwell, DNP, FNP-BC, FAANP/The Nurse Practitioner Association New York

Proposal Description: Remove the requirements for written collaboration agreements and written practice protocols between nurse practitioners and physicians.

Problem Statement: (specify what problem the proposal is seeking to address. If limited to a certain setting within a sector (e.g., home care), indicate why the proposal is focused only on that setting)

Nurse Practitioners (“NPs”) are autonomous health care practitioners who are authorized to: diagnose illness and physical conditions, perform therapeutic and corrective measures, order tests, prescribe medications, devices and immunizing agents, and, when appropriate, refer patients to other healthcare providers, without supervision.¹ Numerous studies show that NPs deliver high-quality, cost-effective, safe health care to diverse populations. They are highly trained and experienced individuals who exercise independent judgment, and collaborate with multiple specialists and healthcare practitioners every day, much like physicians and other healthcare providers. Despite this independence and training, New York law constrains NPs practice, and limits patients from accessing NP services by requiring that NPs enter into a collaborative practice agreement with physicians.² This statutory requirement creates a barrier to practice and is an impediment to the expansion of needed primary care capacity in New York. It also adds excess costs to the system when NPs and/or health facilities are forced to reimburse collaborating physicians for this service. Notably, NPs are experiencing difficulty in identifying physicians who are willing to sign such an agreement. This restricts access to primary healthcare for New York’s diverse populations, especially individuals and families in urban and rural underserved areas of the state. 19 other states, including the District of Columbia, already allow nurse practitioners to practice without any written collaborative agreement requirement.

¹ N.Y. Education Law § 6902

² *Id.*

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Benefits of Proposal: Eliminating this barrier will increase access to quality healthcare for Medicaid recipients, while reducing costs to the system. NPs are proven in numerous quality studies to have low hospital admissions and readmission rates, higher immunization rates, and improved compliance rates to health regimens.³ NPs provide access to both urban and rural populations, and are often the only primary care providers to Medicaid recipients in those areas. They provide care to high volume of patients in the State government programs (Medicaid Managed Care, Child Health Plus and Family Health Plus), which is even more critical in order to ensure appropriate access consistent with the implementation of federal healthcare reform.

Impact on Stakeholders: (describe the expected effect as it relates to the following with particular emphasis on the effect on Medicaid consumers and the NYS Medicaid program)

Medicaid recipients, the NP community, physicians, hospitals, and tax payers will all benefit from this proposal. NPs will be able to better serve the public, and healthcare consumers will have more quality healthcare providers to choose from. Physicians will benefit as there will no longer be a need for these doctors to engage in the administrative obligations that come a long with entering into a written collaboration agreement with NPs. Taxpayers will see savings associated with lower hospital admission and readmission rates, improved immunization rates, and improved compliance rates. Finally, hospitals will benefit by fewer inappropriate Emergency Room visits for non-emergency diagnoses.

Impact on Health Disparities: See attached sheet

This proposal will result in greater access to healthcare, which should result in a reduction in health disparities. NPs already provide services to a disproportionate number of Medicaid patients.

Impact on Quality of Care: Quality of care will be improved as the Medicaid population will have greater access to healthcare professionals.

Impact on Medicaid Costs: Medicaid costs will be reduced, based on the Medicaid rate differential. More patients will have access to low cost, high quality care.

Impact on Medicaid Efficiency: This proposal will result in a more efficient use of government funds by providing access to primary and preventative care and avoiding emergency room presentation and subsequent hospital admissions.

³ See, e.g., *The Future of Nursing: Leading Change, Advancing Health*, Institute of Medicine, Washington, DC: The National Academies Press (2011); *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, National Council of State Boards of Nursing (NCSBN), APRN Joint Dialogue Group Report (2008); *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, *Nursing Economics*, Vol. 29, No. 5 (2011).



Implementation Complexity: There is no anticipated barriers to implementation of this proposal once the statutory change is made.

Required Approvals:(state the required state actions from among the following list necessary to implement the proposal. Provide specific sections of state law or regulations or specific action needed.

Administrative Action: Yes/No
Statutory Change: Yes/No
State Plan Amend: Yes/No
Federal Waiver: Yes/No
Other: Yes/No

Implementation Timeline: Implementation of this proposal can occur immediately upon enactment.

Concerns Regarding the Proposal: None

Include, where possible, one additional page citing research and/or evidence, including experience in other states, that you believe is relevant for the work group to consider.

- 19 other jurisdictions allow nurse practitioners to practice with complete autonomy and do not require a written collaborative practice agreement. (AK; AZ; CO; DC; HI; ID; IO; ME; MD; MT; ND; NH; NM; OR; RI; UT; VT; WA; WY).
- A similar written collaborative agreement requirement was eliminated for midwives in 2010. See Chapter 238 of the Laws of 2010.
- An October 2010 report by the Robert Wood Johnson Foundation Institute of Medicine (“IOM”) recommends nurses should be able to “fulfill their potential as primary care providers to the full extent of their education and training” and that “restrictions on scope of practice...undermine the nursing professions’ ability to provide and improve both general and advanced care.” *The Future of Nursing: Leading Change, Advancing Health, Institute of Medicine, Washington, DC*. For more information on the role and safety outcomes regarding nurse practitioners, see: The National Academies Press (2011), *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, National Council of State Boards of Nursing (NCSBN); APRN Joint Dialogue Group Report (2008); *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review; Nursing Economics*, Vol. 29, No. 5 (2011); *Medicaid Report Card - Primary Care: Expanding the Use of Nurse Practitioners*, http://www.communitycatalyst.org/resources/medicaid_report_card/submetrics?id=0004; *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Rand Health (See Page 19 of Executive Summary on NP Cost Savings); *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*, Kaiser Family Foundation.

- For information regarding the need to increase access to healthcare professionals, including nurse practitioners, see: [Help Wanted: New York's Physician Shortage Continues to Worsen](#), Healthcare Association of NYS (2011).

MRT WORKGROUPS DISPARITIES IMPACT STATEMENT

Given the serious health inequities among New Yorkers, the MRT Disparities Workgroup has developed the questions below, which if answered can serve as a *Disparities Impact Statement*. The questions are intended to sensitize the MRT Workgroups to the effects proposals may have on different populations. The populations considered in the questions are based on the populations suggested by the US Department of Health and Human Services (DHHS) pursuant to Section 4302 of the Affordable Care Act (ACA), which requires that by 2012, federally-supported programs like Medicaid and Medicare collect and report data from program applicants and participants across five demographic categories (race, ethnicity, sex, primary language, and disability status). In addition, the Disparities Workgroup recommends New York State consider effects based on gender identity and sexual orientation. DHHS is in the process of validating standard approaches for collecting data within these categories but has not yet released guidance.

1. Did the Work Group discuss this proposal's potential effect on disparities in access to care and disease incidence?

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	X		
Female	X		
People with a primary language other than English	X		
People of Hispanic, Latino, or Spanish origin	X		
People who identify as:			
White	X		
Black or African American	X		

American Indian or Alaska Native

X

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Asian ⁱ	X		
Native Hawaiian or Other Pacific Islander ⁱⁱ	X		
People with a disability ⁱⁱⁱ	X		
People who identify as transgender ^{iv}	X		
People who identify as lesbian, gay, bisexual, or questioning ⁴	X		

Additional comments:

2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders? Y N

3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities?

Y N If Yes, please describe conclusions:

Although specific conclusions cannot be made at this time, it is possible to review and monitor the health care outcomes that have been experienced in the 19 other states where there is no requirement for a nurse practitioner to have a written collaborative agreement with a physician.

ⁱ Includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian

ⁱⁱ Includes Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander

ⁱⁱⁱ Includes people who: have difficulty hearing; have serious difficulty seeing even when wearing glasses; because of a physical, mental, or emotional condition, have serious difficulty concentrating, remembering, or making decisions; have serious difficulty walking or climbing stairs; because of a physical, mental, or emotional condition, have difficulty doing errands alone such as visiting a doctor’s office or shopping,

^{iv} NYS Disparities Workgroup recommendation not included in the ACA