The New Frontier

Expansion of Non-Physician Practitioner Scope of Practice

by Beth Christian and Frank Ciesla

There is a fundamental change occurring in the delivery of healthcare services in the United States. The enactment of the federal Patient Protection and Affordable Care Act has increased access to healthcare services for persons who were previously uninsured.[1] The U.S. Department of Health and Human Services has projected that by the year 2020, there will be a shortage of 20,400 primary care physicians in the United States due to the aging of the population, overall population growth and increased access to health insurance.[2] In addition to the increased demand for healthcare services, there are also increased pressures to deliver healthcare services more efficiently and at a lower cost.

In order to meet the demand for healthcare, non-physician practitioners, such as advanced practice nurses, physician assistants and others, will be called upon to fill the gap. Telemedicine will be used in more healthcare settings. In anticipation of these changes, a number of states recently have expanded their scope of practice laws and regulations for non-physician practitioners, although changes to scope of practice rules in these states are not uniform and vary significantly from state to state. A recent U.S. Supreme Court decision, as well as the expansion of scope of practice laws and regulations in other states, may serve as the impetus for a similar expansion in New Jersey.

New Jersey courts have upheld the right of hospitals to limit the category of practitioners who may be granted staff privileges, including chiropractors, psychiatric nursing specialists and oral surgeons.[3] New Jersey courts have also upheld regulations that limit the ability of a certified registered nurse anesthetist (CRNA) to administer certain types of anesthesia without physician supervision. The New Jersey Association of Nurse Anesthetists (NJANA) has filed two separate lawsuits challeng-

ing regulations of the Board of Medical Examiners and the Department of Health, which limited the ability of CRNAs to administer anesthesia without physician supervision.

In *N.J. State Association of Nurse Anesthetists, Inc. v. N.J. State Board of Medical Examiners*, NJANA challenged proposed regulations of the New Jersey Board of Medical Examiners governing the administration of anesthesia in a physician office setting.[4] The proposed regulations required that CRNAs only administer certain types of anesthesia in an office setting under physician supervision. The CRNAs argued that the rules were arbitrary, because there was a lack of evidence they would enhance patient safety. The Supreme Court disagreed, finding that the wealth of testimony adduced at the public hearings on the regulations supported the need for enhanced education and oversight. The Court also found it was "fundamentally reasonable" that an anesthesiologist's additional education and training would enable him or her to better protect patients when complications occur.

Recently, in *New Jersey Association of Nurse Anesthetists, Inc. v. New Jersey Department of Health & Senior Services*, the NJANA challenged the validity of regulations requiring the physical presence of a collaborating anesthesiologist during induction, emergence and critical change-in-status when a CRNA administered general or major regional anesthesia, conscious sedation or minor regional blocks in a hospital.[5] The Appellate Division held that: 1) the Department of Health had the authority to regulate the staffing of certain services in licensed healthcare facilities; 2) the department was not regulating the practice of nursing; and 3) the law applicable to CRNAs did not grant the practitioners the authority to administer anesthesia without supervision. The Appellate Division also held that the department's regulations did not conflict with the scope of practice regulations of the Board of Medical Examiners or the Board of Nursing.

These decisions demonstrate that New Jersey's courts have upheld: 1) the authority of hospitals to limit the categories of professionals who may participate as adjunct or allied staff members; and 2) the authority of state professional boards and other state agencies to exert broad oversight, not only over licensees subject to direct regulation by that board or agency but also indirectly impacts the activities of other professionals who are not subject to direct regulation by that board or agency.

On a national level, scope-of-practice laws vary tremendously from one state to the other, with each state setting its own rules and parameters for the scope of practice of individual practitioners. In addition, third-party payors vary in their approach regarding whether they will pay for a particular medical procedure or service if the procedure or service is performed by a plenary licensed physician versus an individual with a more limited license. However, with the United States Supreme Court's recent decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission,*[6] it may be more difficult for state agencies regulating the professions to extend their reach to regulate the activities of non-licensees.

The *Board of Dental Examiners* case involved an attempt by the North Carolina Board of Dental Examiners to regulate teeth whitening by non-dentists. North Carolina law required that six of the eight members of the board be licensed dentists. In the early 1990s, dentists in North Carolina (including a majority of the board members) started whitening teeth, and earned substantial fees for doing so. By 2003, non-dentists started to provide the service, charging lower prices than dentists. The board issued at least 47 cease-and-desist letters to non-dentist teeth-whitening service providers and product manufacturers, which stated that teeth whitening is the practice of dentistry. The letters achieved their desired result, and non-dentists ceased offering teeth-whitening services.

In 2010, the Federal Trade Commission (FTC) filed an administrative complaint charging the board with violating federal antitrust laws. The FTC ordered the board to stop sending the cease-and-desist letters, and to issue notices to all earlier recipients of the letters advising them of the board's proper sphere of authority. The Court of Appeals for the Fourth Circuit affirmed the FTC ruling. Thereafter, the board filed a petition for a *writ of certiorari* with the U.S. Supreme Court. The board argued that it was exempt from the antitrust laws because its members were vested by North Carolina with the power of the state, and were, therefore, cloaked with state action immunity under the Supreme Court's decision in *Parker v. Brown*.[7]

The Supreme Court held that the board did not receive active supervision by the state when it interpreted the North Carolina Dental Practice Act as addressing teeth whitening, and by issuing the cease-and-desist letters.[8] In evaluating the board's actions, the Supreme Court relied on the two-part test for Sherman Act antitrust immunity set forth in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*[9] The Court held that a state board controlled by active market participants cannot invoke antitrust immunity under the Sherman Act, unless: 1) the challenged restraint is clearly articulated and is affirmatively expressed as a state policy, and 2) the state policy is actively supervised by a state official who is not a participant in the market being regulated.

The Supreme Court accepted the board's argument that the first prong of the *Midcal* test (clear articulation) was satisfied, since North Carolina prohibits the unauthorized practice of dentistry. However, the Court also concluded that

the active supervision test was not met, since the board did not receive active supervision from the state when it interpreted the act as addressing teeth whitening and enforced its policy regarding teeth whitening by issuing cease-and-desist letters to non-dentist teeth whiteners.

North Carolina delegated control over the practice of dentistry to the board by statute, but the act says nothing about teeth whitening, a practice that did not exist when the act became effective.[10] The Supreme Court noted that the lack of supervision from the state may have left North Carolina officials unaware the board had decided teeth whitening constitutes the practice of dentistry, and that there was no evidence of any decision by the state to concur in the board's actions against the non-dentists.[11]

The Supreme Court found *Midcal's* active supervision test is an essential prerequisite of *Parker* immunity for any non-sovereign entity—public or private—controlled by active market participants.[12] The Court indicated *Parker* immunity requires the anticompetitive conduct of non-sovereign actors, especially those authorized by the state to regulate their own profession, result from procedures that suffice to make it the state's own. The Supreme Court held the board was not entitled to rely on state-action antitrust immunity under the Sherman Act, and affirmed the lower court decision upholding the FTC's order that the board stop issuing cease-and-desist letters to non-dentists offering teeth whitening.

Since the issuance of the Supreme Court's decision, the FTC has issued staff guidance concerning active supervision of state regulatory boards concerning the regulation of the activities of market participants.[13] The FTC staff guidance provides guidance regarding two questions: 1) when does a state regulatory board require active supervision in order to invoke the state action defense; and 2) what factors are relevant in determining whether the active supervision requirement is satisfied?

In New Jersey, there is a significant amount of state supervision of the activities of the various professional boards. There are more than 20 professional boards, committees and advisory committees regulating the activities of healthcare professionals. All healthcare professional boards fall within the jurisdiction of the New Jersey Division of Consumer Affairs, a division of the Office of the Attorney General. Each professional board's administrative activities are overseen by an executive director, and that individual does not need to be a member of the profession being regulated. In addition, a deputy attorney general is assigned to each professional board and attends the board's meetings. Meetings, other than disciplinary review meetings, are open to the public.

An individual who wishes to appeal from a determination alleging a violation of a professional licensure law or regulation may request a hearing before an independent administrative law judge who is not affiliated with the professional board, with hearing procedures governed by the requirements of New Jersey's Administrative Procedure Act. Regulations of the professional boards are subject to the requirements of New Jersey's Administrative Procedure Act. In addition, other state agencies (including the Department of Health and the Department of Human Services) also have promulgated regulations that impact the activities of licensed healthcare professionals. Therefore, New Jersey may exert more active supervision over its professional boards than the supervision that may exist in other states.

A number of states have expanded the scope of the activities non-physician practitioners may perform, or have otherwise modified their laws and regulations to allow these practitioners to practice more independently than they have in the past. For example, under New York's Nurse Practitioner Modernization Act, nurse practitioners with more than 3,600 hours of practice experience are no longer required to have a collaborative practice agreement with a physician, and can instead opt to have a collaborative relationship with a licensed healthcare facility.[14]

According to the American Academy of Nurse Practitioners, 21 states now allow nurse practitioners/advanced practice nurses to practice independently without physician oversight.[15] Additional states are considering similar legislation.[16] A recent article in *Forbes* magazine indicated that nurse practitioners and physician assistants are, in some cases, more highly pursued by recruiting companies than some medical specialties.[17]

In California, nurse practitioners, certified nurse-midwives and physician assistants are now permitted to perform first-trimester abortions.[18] In addition, pharmacists in both California and Oregon are permitted to prescribe birth control pills without a physician prescription.[19] An article in *USA Today* reported that nurse practitioners and physician assistants in some states replace chest tubes, interpret EKGs, and serve as first assistants at surgery (among other tasks), functions that were once the sole purview of physicians.[20] In addition, LabCorp has started a direct-to-consumer business that will allow individuals to order their own lab tests and access results online, without visiting a physician.[21]

In addition, a new regulatory exception under the federal Stark physician self-referral law was included in the 2016 Medicare physician fee schedule final rule.[22] Under the final rule, hospitals, federally qualified health centers, and rural health clinics will be permitted to provide remuneration to a physician or a physician practice in order to

assist the physician in recruiting and employing certain non-physician practitioners, including physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives.[23] The Centers for Medicare and Medicaid Services (CMS) indicated in the preamble to the final rule that its goal in proposing the exception for reimbursement of the recruitment expenses was to promote the expansion of access to primary care services.

While New Jersey has not been as proactive as some other states in expanding the scope of non-physician practice, there has been some expansion in recent years. In May 2015, the New Jersey Legislature amended the law concerning pronouncement of death to allow an advanced practice nurse to determine a patient's cause of death and execute death certificates if the advanced practice nurse is the patient's primary caregiver.[24] Pharmacists may now administer vaccines to individuals age seven and older.[25] Chiropractors may perform EMG and VONT testing.[26] Podiatrists may supervise and administer hyperbaric oxygen therapy.[27] The Board of Medical Examiners also expanded the scope of practice for acupuncturists by allowing them to perform certain adjunctive therapies and recommend to patients the use of certain medication and supplements.[28]

Another area where the scope of healthcare service delivery is expanding is telemedicine services. In New Jersey, practitioners who perform telemedicine or other telehealth services (such as teleradiology) must be fully licensed to practice their profession in New Jersey. The current scope of telemedicine services is governed by the policies of various third-party payors. For example, under Medicare reimbursement rules a service is considered to be a physician's service (and therefore reimbursable) when the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third-person's judgment.[29] For example, the interpretation of an electrocardiogram or an electroencephalogram that is transmitted telephonically is a covered service. Other telemedicine services are currently covered by Medicare only if they are provided in locations that are rural health professional shortage areas and are located outside of a metropolitan statistical area or in a rural census tract.[30]

The New Jersey Medicaid program issued a policy in Dec. 2013 that allows psychiatrists and psychiatric advanced practice nurses to provide telepsychiatry services to patients in mental health clinics and in hospital outpatient mental health programs as long as the patient consents and certain other criteria are met.[31] A bill currently pending before the New Jersey Legislature would require all health insurance carriers, the State Employee Health Benefit Program and the School Employee Health Benefits Program to provide coverage of telemedicine services.[32] These initiatives will expand the location of patient evaluations beyond the traditional in-office or healthcare facility setting and, like the expansion of the scope of practice for non-physician practitioners, will revolutionize the delivery of healthcare services.

It will be interesting to see how New Jersey's professional boards, other state agencies and third-party payors react and adapt to the expansion of the scope of practice of non-physician practitioners, as well as the increased use of telehealth services. With the confluence of ever-increasing healthcare costs and the development of new models for healthcare service delivery, one thing is certain: Change is inevitable. ⚖

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