Approved 2/26/90
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

The meeting was called to order by SENATOR RICHARD L. BOND at
Chairperson

9:00 a.m./~~p.m.~~ on THURSDAY, FEBRUARY 22, 1990 in room 529-S of the Capitol.

~~All~~ members ~~were~~ present ~~except:~~
Senators Karr, Kerr, McClure, Moran, Parrish, Reilly, Salisbury, and Strick.

Committee staff present:
Bill Edds, Revisors Office
Bill Wolff, Research Department
Louise Bobo, Committee Secretary

Conferees appearing before the committee:
Debbie Folkerts, Kansas State Nurses Association
Dr. Carl P. Newman, Cloud County Medical Society
Charlotte Peake, Kansas State Nurses Association
Patrick Griffin, Administrator, Washington County Hospital
Linda Sebastian, Clinical Nurse Specialist in Psychiatry
Judith Haffner, ARNP
Mary Jane Whelan, Kansas Alliance of Advanced Nurse Practitioners
Susan Hasselle, Clinical Specialist in Psychiatric Nursing
Micki Zenger, Administrator, Rural Health Clinic
Carla A. Lee, Ph.D., Wichita

Chairman Bond called the meeting to order at 9:15 a.m.

SB 633 - Providing for reimbursement of services performed by advanced registered nurse practitioners under health and accident policies.

Chairman Bond requested Dr. Wolff to present a brief summary of the above mentioned bill. He explained that the New Section 1 would require the insurer to pay benefits under a contract for services rendered whether by a licensed physician or an advanced registered nurse practitioner (ARNP). Section 2 makes the statute applicable to all policies used within or outside of the state by an individual residing or employed in the state. Section 3 applies the mandate to Blue Cross Blue Shield. Section 4 repeals certain statutes and Section 5 makes the act effective on publication in the statute book.

Debbie Folkerts, Kansas State Nurses Association (KSNA), addressed the committee in support of this measure. She emphasized that the major health insurers fail to recognize that the role of the ARNP is different from that of an RN but that nineteen other states have recognized the cost effectiveness and have legislatively addressed third party reimbursement to ARNPs. (Attachment 1)

Carl T. Newman, M.D., spoke before the committee in support of SB 633. Dr. Newman informed the committee that, in the six rural counties which he serves, there is a shortage of physicians as there is in other rural areas. He continued that it is unrealistic to expect this shortfall to be remedied by recruiting physicians and that part of the problem could be relieved by using ARNPs. In addition, use of these health care providers would lower the overall cost of medical care. (Attachment 2)

Charlotte Peake, ARNP, Belleville, urged the committee to support SB 633. She said that studies had proven that direct reimbursement to ARNPs for covered services had not resulted in increased premium costs. Ms. Peake also informed the committee that business and government organizations had found it advantageous to have ARNPs provide on site medical care for their employees. She concluded her remarks by stating that the federal government recognizes ARNPs as cost effective health care providers and she urged that Kansas do the same. (Attachment 3)

Patrick Griffin, Administrator, Washington County Hospital, supported the proposed legislation. Mr. Griffin said that the ARNP provides a viable alternative to the physician. An ARNP does not replace a physician but does supplement many services under written local protocol. Local protocols are updated annually by the physician taking into consideration the ARNP's education, training, and skill. (Attachment 4)

Linda Sebastian, Clinical Nurse Specialist in Psychiatry, testified in support of this proposal. Ms. Sebastian informed the committee that insurance companies will pay for master's level social work or counselors which are comparable to her educational level but will not pay for her services. Ms. Sebastian quoted a national journal for hospital administrators as saying that, by the year 2000, nurses will be the primary caregivers for the chronic and degeneratively ill. (Attachment 5)

Judith Haffner, ARNP, next addressed the committee in support of SB 633. Ms. Haffner enumerated the many ways in which she, a specialist in Surgery, Emergency, and Trauma, assists her surgeon in their rural setting which results in saving significant sums of money for the insurance companies. (Attachment 6)

Mary Jane Whelan, ARNP, informed the committee that nurse practitioners were registered nurses with advanced education and clinical training. Ms. Whelan told the committee that the ARNPs fill a major gap in primary care in rural areas. She further stated that 58% of practitioners live in towns with a population of less than 20,000. She concluded by stating that health care in Kansas will continue to suffer due to poor physician distribution and that the use of nurse practitioners in primary care would increase accessibility of health care for rural Kansas. (Attachment 7)

Susan Hasselle, Clinical Specialist in Psychiatric Nursing, addressed the committee in support of this proposal. She advised the committee that she could provide quality care at a lower rate than a psychiatrist. However, she stressed that her patients do not come to her because of lower costs but because of her reputation as a therapist. She also stressed that nurses need incentives to stay in the profession and that it was discouraging to witness the current discrimination. (Attachment 8)

Micki K. Zenger, Administrator, Rural Health Clinic, urged the committee to support this bill. Ms. Zenger said that, since January, 1990, she had not been reimbursed for her services by Blue Cross Blue Shield but was still reimbursed by Medicare and Medicaid. She stressed that this elimination of coverage for nurse practitioners would adversely affect employment of ARNPs and limit patient's choices. (Attachment 9)

Carla A. Lee, Ph.D., Wichita, informed the committee that Kansas had been a forerunner in the nation with regard to role development for advanced practice as early as the 50s. She said it was now time for Kansas to closely examine health insurance laws specific to reimbursement. (Attachment 10)

The minutes of Tuesday, February 20, 1990, were approved on a motion by Senator Kerr with Senator Karr offering the second. The motion carried.

After informing the committee that the hearing on SB 633 would be continued on Monday, February 26, Chairman Bond adjourned the meeting at 10:04 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Thurs. Feb. 22, 1990

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Pamela Byl	231 Elmwood Topeka	KSNA
Mary Davis	11307 W. 1st Wichita	KSNA
Patsy Quint	2805 S. 147th St. E. Wichita Ks. 67232	KSNA.
Linda Sebastian	6348 SW 23rd/Topeka	KSNA
Candace Byrne	2507 Monterey Dr.	Menninger's
Deborah S. Rose, RN	Rt 2 Box 164 Overbrook, KS	VA Hospital / KSNA
Emma Buhr RN	3712 SW 29th #536 Topeka, KS 66614	Menninger's
JUDITH HAEFNER, ARNP	EL DORADO, KS 67042. 111 S. Summit B-2	BUTLER COUNTY SURGICAL GROUP - AND K.S.N.A.
Debbie Folkerts	Concordia	KSNA
CARL NEWMAN	CONCORDIA KS	CLOUD COUNTY MED SOC
Bonna Newman	Concordia KS	Tax payer
Bill Pitsenberger	Topeka Kansas	BLUE CROSS
Dwight Wicker	Topeka, Kansas	Blue Cross / Blue Shield
Mark Braun	Topka, Kansas	A.G.'s office
Mark Stafford	Topeka	AG
Chip Wheeler	Topeka	KS Medical Soc.
Susan Runyan RN	TOPEKA.	KSNA
Nancy J. White RN	Emporia, Ks	Lyon Co. Health Dept
Abby Hanak R.N.C.	Emporia	KSNA: Lyon Co H.D.
Jan Noyes R.N.C.	Emporia	KSNA: Lyon Co Family Planning Lyon Co H.D.
ALAN COBB	TOP	KS RESP CARE SOC.
Susan Hasselle	RR# 2 Box 247A	Lawrence, KS 66046
Charlotte Lake	2540 Sunset Dr. Belleville	KSNA
Mary Jane Wheaton, ARNP	Rt 1 Box 25 St. Paul, Ks.	KAANP

Attachment 2/22/90

KSNA

the voice of Nursing in Kansas

Debbie Folkerts A.R.N.P.
1415 Highland Drive
Concordia, Kansas 66901
(913-243-2511)

February 22, 1990

Chairman Bond and Members of the Senate Committee of Financial Institutions and Insurance:

My name is Debbie Folkerts. I am a Certified Advanced Registered Nurse Practitioner and Chair of the Advanced Practice Conference Group of the Kansas State Nurses Association. I would like to speak to you this morning regarding the crisis of health care and Nurses in Advance Practice.

Nurses in Advanced Practice are Registered Nurses who after actively practicing return for additional education that allows them to practice in the expanded role. These Practitioners preform physical examinations, manage acute and chronic illnesses, prescribe medications under protocols and have the comprehensive skills to expeditiously refer patients to physicians when indicated.

On January 1 1990 the major health insurance provider to Kansans terminated its reimbursement to Advanced Registered Nurse Practitioners. This providers premiums consists of a total of approximately $499,886,583.00 annually in comparison to all other health insurance providers in the State totaling $492,615,293.00. Therefore this policy has created a crisis in access in our rural areas where providers are extremely limited.

The reason for this policy change? There have been multiple attempted explanations. On intial filing with the Insurance Commission this provider stated they were only clarifying current policy and ARNP'S had never been issued provider numbers. The fact is provider numbers had been issued however, they were issued as RN numbers and payment was invariably denied.

It was very discouraging to find they still refuse to acknowledge that ARNP's function differently that RN's. We have been termed as a" bundling" of the physicians services. I am still unsure of what type of bundle we are? However, I do know that we are not a content of a physicians service. This is a term that is used for a R.N. or office assistant when they replace a bandage, take a blood pressure,or pass instruments during a surgery. The same bundling of service is included when the ARNP's nurse takes a blood pressure or replaces a bandage it is a content of the ARNP'S service. An ARNP would be similar to the assistant surgeon or a physician assistant, providing control of bleeding,suturing,

Attachment 1
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2/22/90

and assisting with control of bleeding and assisting with the postoperative management including daily visits to the patient. However,we cannot be reimbursed.

This major health care insurer claims they are concerned with health care cost. I fail to see the cost savings when the amount billed to an insurance company under my name for an office visit is $16.00. When forced to bill under the physicians name I have to use his fee schedule at the rate of 26.53 for the same service. Another senerio, a yearly women's health physical billed with my fee schedule is $40.00 this includes lab,physical and health teaching. Billing through the physicians name the same service is $95.00. The real intent is increasingly clear when provided with correspondence which states the real intent is to prevent independent practice by nurses apart from physicians.

ARNP'S practice in a colaborative role with physicians. We must have protocols established with physicians to practice. It would be fraudulent to submit a claim with the physicians name as provider when in acutuality he did not see the patient. Due to financial constraints in rural areas consumers are forced to seek care only from providers recognized by insurers,85% of americans rely on third party payers. Extensive involvement of third party payers has contributed to rising costs and lack of competition in the health care system due to hospitals and physicians being the major providers recognized by these payers and entry into the system being restricted to others. The Office of Technology Assessment policy concluded ARNP'S improve quality and accessibility of health care services, increase productivity of medical practices and institutions and are cost-effective.

To date nineteen states have recognized this cost effectiveness and have legislatively addressed third party reimbursement to Advanced Registered Nurse Practitioners. There are seven states which voluntarily reimburse ARNP'S without legislation, and fifteen states are legislatively addressing this subject this session. I personally telephoned the nineteen states which currently reimburse I selected Blue Cross Blue Shield as the informant since this insurer is nationwide. All communicated cost savings by reimbursing Advanced Registered Nurse Practitioners services due to their fees being generally less expensive and the drastic increase in access preventing more critical illnesses and expensive hospitalizations. Alaska and Washington sent documentation of this statement with the addition of the concept being a popular subscriber choice. It was also interesting to note Alaska, asked that I send some Advanced Registered Nurse Practitioners their direction. They would be glad to reimburse for services and may even find a way to pay moving expenses.

Reimbursement policies have not kept pace with the evolution of state legislation regulating the practice of ARNP'S which allows for collaborative practices with direct accountability to the consumer. Kansas is facing a crisis of rising health care cost and lack of access to health services. The Advanced Registered Nurse Practitioners of the State of Kansas are committed to providing Kansans with accesible cost-effective health care. Please allow us this right. Vote for SB 633.

Blue Cross®
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111-0327
206/361-3000

FEB 20 RECD

February 20, 1990

Debbie Folkerts
Midwest Urologic
910 West 11th St.
Concordia, Ks. 66901

Dear Debbie:

I am writing at your request to confirm our conversation we had last week.

You asked if we at Blue Cross of Washington and Alaska cover services provided by Nurse Practitioners. I told you yes we do cover their services and in fact we also contract with Nurses to join our Preferred Provider Network.

You also asked if I felt that we see a savings by covering Nurse Practitioners. It is my opinion that as an average of Statewide charges, the nurses charges are less than physician charges and thus gives us a savings. We have found that covering services provided by Nurse Practitioners to be cost effective and popular with our subscriber population.

If I can be of any further assistance feel free to call me at (206) 361-3321.

Sincerely,

Gregory A. West

Gregory A. West
Physician Services Coordinator

Testimony of

Carl T. Newman M.D.

Representing the

Cloud County Medical Society,

Midwest Urologic Associates, P.A.,

And the Urologic patients of

Smith, Jewell, Republic, Washington, Mitchell and Cloud

Counties

I would like to thank the Senate Committee on Financial Institutions and Insurance for the opportunity to testify on a bill which should have a significant positive impact on both the availability and affordability of health care to the citizens of rural Kansas.

For the past 9 years I have provided a majority of the Urologic care for the six North Central Kansas Counties previously listed. In July, 1986 there were 38 physicians living and practicing in these six counties. Today there are 24. Taking into account attrition due to age and infirmity and physicians who have expressed an intention to relocate allows a projection of 14 physicians by the year 1994. With today's nationwide shortage of rural physicians it is unrealistic to expect that the present and projected future health care manpower shortage will be solved by recruiting physicians. Part of the health care manpower shortfall could be relieved by using advanced registered nurse practitioners.

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2/22/90

At the present time Kansas law allows these individuals to provide specific services under specific conditions but the majority of Kansas third party payors will not reimburse the cost of providing these services. This dichotomy has prevented these advanced non-physician providers from helping relieve the burden of our overworked rural physicians. I would like to relate an example of how an advanced registered nurse practitioner could be used in one of the communities I serve.

In one of the communities the few remaining local physicians are having difficulty keeping up with the extensive paperwork required to document the care of their nursing home patients. Several of the nursing homes are negotiating with an itinerant physician's service to care for their patients. The advantage to the nursing home would be that the itinerant physician would fly in every two weeks to see the patients and keep up the paperwork. The disadvantage to the nursing home patients is that their physician will be 200 miles away. If something goes wrong in the middle of the night decisions will be made over the telephone. I don't know the exact financial details but it is hard for me to imagine that an itinerant physician can provide these services including communications and transportation less expensively than a local physician could with the aid of an advanced registered nurse practitioner. I also find it hard to believe that the quality and compassion of care will be any better than could be provided locally.

Belleville

For the past 6 years my corporation, Midwest Urologic Associates, P.A. has employed an advanced registered nurse practitioner at a cumulative cost of over $180,000.00. Less than 10% of the services this individual has provided to the residents of North Central Kansas has been reimbursed. Her services regularly include assisting in surgery, and seeing patients when I would otherwise be unavailable. 90% of the services she provides would be reimbursed if they were provided by a physician or a physician's assistant. In the short term this situation would seem benefit our patients by decreasing the overall cost of medical care. In the long term, however, the availability of care will be further decreased. We are unable to continue to adsorb the expense of this individual and were forced to give her termination notice earlier this month.

Physician extenders such as advanced registered nurse practitioners generally bill and are reimbursed at levels below that of physicians for similar services. If it is assumed that all services rendered are necessary, these individuals should lower the overall cost of health care. Many citizens in rural Kansas are presently severely underserved. The resulting monetary savings to the health care system are at the expense of the health of individuals who are my patients and your constituents.

I would like to thank the Committee for their time and attention in considering Senate Bill 633 and would like to encourage favorable consideration of this bill.

Charlotte Peake, A.R.N.P.
2540 Sunset Drive
Belleville, Kansas 66935
(913) 527-5749

TESTIMONY BEFORE THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

February 21, 1990

Chairman Bond and Committee Members:

My name is Charlotte Peake and I am an Advanced Registered Nurse Practitioner (ARNP) certified in family practice and gerontology. I come before you today to seek your support for Senate Bill 633.

Opponents of this bill will tell you that it will raise health care costs and that it will increase costs to insurance companies. This simply is not so. Because of the 19 states which have mandated reimbursement for covered services to these providers, there is enough data now to refute these statements. For example, New York State has had reimbursement to ARNP's since 1984. At the time the bill was presented to the legislature, opposition argued that mandating direct reimbursement to nurses would be costly and unnecessary. The facts proved them wrong on both counts. Adding these practitioners to the list of providers who can be paid directly by insurance companies did **not** increase premium costs. Major insurance companies like Mass Mutual, Blue Cross/Blue Shield, and Prudential are providing reimbursement to ARNP's for **covered services** at **no** additional cost.

The United States is known to have the poorest access to the most expensive health care system in the world. Some of the reasons for this include:

1. The system is difficult to access and negotiate.

2. The system has emphasized maximum technology with most of the health care dollar going to a small fraction of the population to support the last few months of life.

3. Through regulatory and reimbursement mechanisms, the system pivots around physician care, not the use of appropriate alternate personnel.

4. Prenatal and maternity care which has been found to return $3.00 for each one dollar invested is undersubsidized.

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2/22/90

Advanced Practice Nurses should be seen as a solution to the problem of rising health care costs. They generally charge lower rates for the same quality health care provided by physicians. As a result, many astute executives in business and government have found it advantageous to have Nurse Practitioners provide on-site health care for their organizations. A 1986 study by the United States Congress Office of Technology Assessment found that "within their areas of competence, Nurse Practitioners provide care whose quality is equivalent to that of care provided by physicians". This translates into the ability to manage 75 - 80% of adult primary care services and up to 90% of pediatric primary care services. In this same study researchers concluded savings from the widespread use of ARNP's would be from 10 - 15% of all medical costs (or from $300 to $450 million) and that the savings would have amounted to between 16 and 24% of the total costs for ambulatory care. Furthermore, the researchers determined that their estimates would be as valid in the future as they are today. Considering these savings a better question might be, "why wouldn't health insurers want to reimburse ARNP's"?

ARNP's in this state are distressed to learn of situations such as the one in Reno County where there are presently 100 -/20(pregnant women who are unable to access the health care system and obtain prenatal care. ARNP's are even more distressed by the fact that they are powerless to help solve this problem, despite the fact that they have the ability to provide this care and are permitted by their licensure to do so.

This past session the United States Congress passed laws granting Medicare reimbursement to ARNP's, allowing them to deliver care to the nation's elderly in nursing homes and also granting Medicaid reimbursement to ARNP's. The federal government recognizes ARNP's as cost effective health care providers. The time has come for the health insurance industry in this state to do the same.

ARNP's are not meant to totally replace physicians. However, we can work well together in a collaborative relationship. Through third party reimbursement, ARNP's will be able to function in satellite clinics or allow the physician to work in a satellite clinic while the ARNP remains in the main office, delivering primary care. Access to health care will thus be improved. Also, it will allow separate fee schedules by ARNP's, which will result in lower costs.

Thank you very much for the opportunity to appear before you today. I will be happy to answer any questions you may have.

Washington County Hospital
304 East Third Street
Washington, Kansas 66968

Senate Insurance Committee
Kansas State Senate
Topeka, Kansas 66612

22 February 1990

Dear Mr. Chairman,

I am the Administrator of the Washington County Hospital, Washington, Kansas, a small town in northeast Kansas, and I support the proposed legislation. My objective is to describe the role of the Advanced Registered Nurse Practitioner at the Rural Health Clinic in Washington, to show the negative effects of the Blue Cross reimbursement policy change of 1 January 1990, and to refute the basis upon which Blue Cross and other insurers have used for that change.

The Advanced Registered Nurse Practitioner, or ARNP, fills a vital role in ensuring access to quality health care at reasonable cost for our community. Washington has only one physician, and if he takes one of his very rare days off, our residents are left without a physician in town. In addition, his patient load is so heavy that many times walk-in patients must wait for hours to see him. Patients then tend to defer their visit to him, and this results in the worsening of minor illnesses and sicker patients needing more expensive treatment. Attempts to recruit another physician for this town have failed to date. This community has been designated as a medically underserved area, and a Rural Health Clinic has been established pursuant to the Rural Health Clinic Services Act of 1977, which also delineates the ARNP role.

The ARNP provides an alternate entry point into the health care system. The ARNP does not replace a physician, but supplements his (or her) capabilities, evaluating and treating patients under written local protocol. Based on national protocols, local protocols are developed and annually updated after thorough review by the physician of the ARNP's education, training, and demonstrated skills. If the patient's condition (per protocol) indicates that the patient needs to be seen by a physician, the ARNP will refer the patient to a physician, similar to the action of a Family Practice physician referring a patient to an cardiologist or other specialist (where <u>both</u> physicians are paid for their services). The physician is also available to the ARNP for telephonic consultation, and provides continuing education to the ARNP.

Sometimes, after their first visit to the ARNP, patients <u>prefer</u> to return. Their reasons vary from simply a personal preference, to gender reasons (our ARNP is a female whereas the town physician is a male), to the lower cost of a visit to the ARNP. Again, their ready access to health care enables earlier intervention in their illnesses. When, patients found out that Blue Cross would no longer pay for care delivered by the ARNP, they were extremely upset.

I've shown how the ARNP can increase access and how quality is ensured. Our Rural Health Clinic has undergone numerous evaluations by representatives of Medicare and Medicaid, and has always been recertified for their reimbursement. I cannot understand why insurers feel that they can deny payment for services which our federal government deem appropriate. I have seen a letter from a major insurer in this state which explains their position. I will address the points made in that letter and show how they seem in my view to be arbitrary and capricious, and appear to me to be founded upon erroneous beliefs.

The insurer believes that physicians are billing for services performed by their

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2/22/90

own employed nurses, which is certainly not the case in Washington. Our ARNP, while relying upon the physician for clinical supervision and consultation as discussed earlier, is not employed by the physician, is not physically collocated with the physician, and has not billed through the physician. Evidently, the insurer has had problems with other physicians who were allowing nurses employed in their offices to bill separately for services which were part of a regular office visit to the physician. This is termed unbundling, which is not allowed by Medicare and other insurers. Instead of identifying and confronting these specific violators, physicians or nurses, the insurer apparently took the easy way out and banned all separate payments to nurses (less nurse anesthetists and home health nurses).

The insurer apparently cannot differentiate between an ARNP and other nurse categories and their capabilities. As a case in point, Blue Cross representatives still refuse, in either ignorance or arrogance, to address the ARNP at Washington by her professional designation. They insist instead in addressing her simply as an RN. Whether this failure to accord our ARNP her rightful status is a Blue Cross official position, I cannot say. However, I question the lack of nurses on the Blue Cross Board, and I wonder if their lack of representation affects this issue.

The insurer has also stated that physicians who employ nurse practitioners will not be affected, implying that all nurse practitioners are either employed by or financially dependent upon physicians. Another implication is that all physicians support the insurer's viewpoint. These positions are inaccurate and whether they also reflect the composition of the Blue Cross Board, I, again, cannot say.

The insurer has stated that they have a statutory obligation to control costs. The implication is that allowing ARNPs to be reimbursed through separate billing will increase costs. I feel that is an unfounded projection. Many studies have shown that lack of adequate access to health care increases overall costs, due to the increased health care resources that must be then dedicated to healing the sicker patient. Additionally, our ARNP charges less than a physician for the same service. The insurer desires that physicians bill for nurses' (ARNP) services, a practice which will undoubtedly increase the cost of ARNP services, when the physician's administrative overhead fee is added. Also, this approach could arguably be considered fraud under Medicare rules. I cannot comprehend the logic behind this effort to 'control cost'.

Finally, The insurer states that the ARNPs reaction to their policy change represents their attempt to establish independent practices. Again, this appears to be totally unfounded and is apparently another attempt to elicit emotional support for their policy change, especially by other medical professionals. One only has to review the history of Kansas to see the similarity between the ARNP situation and that of Doctors of Osteopathy and Doctors of Chiropractic in years past.

The State of Kansas must continue to advance into the future of medicine in order to provide high quality, accessible, cost-effective health care for all its citizens, especially those in rural communities. I believe that the failure of the insurers to pay for separately billed ARNP services, and the State's endorsement of the the insurers' position, will not result in cost savings and will not result in a higher quality of care. It will decrease access to health care in Kansas, and it sends a very depressing message to the residents of this state. We cannot allow ourselves to be seduced by the irrational logic inherent in the insurers' position.

Original Signed by

Patrick T. Griffin
CEO / Administrator

Testimony for Senate Insurance Committee

Chairman Bond, Members of Insurance Committee:

My name is Linda Sebastian and I am a clinical nurse specialist in psychiatric nursing, which means I have a master's degree in psychiatric nursing. The requirements for my master's degree were 64 hours of graduate credit. This included a year-long supervised practicum of individual psychotherapy, group therapy, family therapy and community case work. Part of my graduate program was paid for by the federal government. Clinical nurse specialists in maternal-child nursing, medical surgical nursing and mental health nursing were able to receive this government stipend because we were seen as viable options in decreasing the cost of health care. The federal government has continued this policy in providing reimbursement for federally funded programs such as Medicare. Completion of my master's degree qualified me for advanced practice in nursing, yet clients who choose my services cannot get their insurance companies to pay for my services. These same insurance companies will pay for master's level social work or counselors which are all comparable to my educational program. So my clients have to pay premiums to their insurance companies and also pay for my services out of pocket, if they choose to use my services.

Why is this the case?

1. In the midwest, nurses in advanced practice are not common. On both coasts, I have colleagues (CNS) who are in private practice for psychotherapy. They are reimbursed by insurance companies routinely.

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2/22/90

Unfortunately, if they were to move to Kansas, they would have difficulty getting third party reimbursement.

2. Blue Cross-Blue Shield have said that they have denied us reimbursement because it drives the cost of health care up. This is illogical. Nurses in advanced practice have proven to provide quality, cost-effective care. My income is not as great as a physician's -- I think I am worth as much, however -- but I don't charge as much for my services. If BC-BS wanted to promote cost-effective care, they should be actively seeking all of the nurses in advanced practice they could find and limiting reimbursement for physicians! Is this a case of physicians not wanting us a competitors? What are they afraid of?

Blue Cross-Shield is seeking to maintain status quo and we can no longer afford the expensive monopoly of physicians controlling health care.

Why should my clients come to me instead of a social worker, a psychologist or a physician?

I can offer quality mental health services. I can offer a holistic view of the patient. With my medical background as a nurse, I know better than a social worker or psychologist when a client needs referral to a physician. I don't pretend to be a doctor -- he has his job to do -- I just want to be able to do what I am capable of doing -- provide therapy for my clients. I do have clients that pay for my services out of pocket even though they have already paid their insurance premium. I have convinced some insurance companies to reimburse me for my services -- it was a matter of educating them to what I am and that I am comparable to an MSW. One insurance

company decided to pay for my services because the client advocated for my services by calling and writing the main office. One of my clients pays a very high premium to BC-BS who refuses to pay for my services. But BC-BS told her that if she switched to a physician, her psychotherapy would be paid for. The physician charges $40/hour more than I do. Am I driving the cost of health care up?

For clients in the rural areas, it is a matter of access. I live in Topeka now, but I am from Western Kansas. If I were to open a practice in my home town of Tribune, clients would not be able to utilize my services because their insurance would not pay for it. There are very few psychiatrists in Western Kansas, yet BC-BS says to the people of Western Kansas that they will only pay for psychiatrists even though a qualified professional option is available. This is unfair discrimination against me, and this is depriving people in Kansas access to quality, cost-effective services.

Health care is changing. In the November 20, 1989 issue of Hospitals, a national journal for hospital administrators, Stephen Gamble, president of Hospital Council of Southern California, wrote in an article titled, "Changing Roles in the '90's: Will RN's manage MD's?"

> "The Physicians' Current Procedural Terminology, a coding system published by the American Medical Association, designates physicians as the only providers of all coded services. Yet many of those services, once provided exclusively by physicians, now have a strong nursing component or are provided solely by nurses (albeit under physician direction or supervision)."

He goes on to say that by the year 2000, nurses will be the primary caregivers for the chronic and degeneratively ill.

Please support SB 633 and allow Kansans access to a viable alternative to health care and an opportunity to choose. By not supporting this bill, you are voting for an outmoded, expensive health care delivery system for Kansans.

Inside Track

Changing roles in the '90s: Will RNs manage MDs?

Editor's note: The following text is adapted from a presentation given by Stephen W. Gamble, president of the Hospital Council of Southern California, Los Angeles, at the 1989 International Hospital Federation (IHF) Congress in The Hague, Netherlands. The presentation will also be published in the 1990 edition of IHF's Hospital Management International.

When the doctors on your medical staff start working for the nurses, how will you cope with the management challenges?

A convergence of factors is irreversibly changing the power structure between physicians and nurses in the hospital, and hospital management is caught in the middle.

For a century, convention has held that only a medical doctor can practice medicine, and a nurse is the physician's handmaiden. Now, however, it appears that convention does not match reality.

The public's image of the ideal physician—who is kindly, capable, caring, and reassuring like Dr. Marcus Welby of television fame—is more often emodied by a nurse.

The demarcation between the roles of physician and nurse is rapidly blurring. And while the nurse wants management to support the changes, the physician expects management to preserve the status quo. Only the skillful manager will avoid being damaged in the process of this change.

Factors affecting the relationship between nursing and medicine include changing technology, increased involvement of nurses in monitoring physician care and other quality-related activities, and the concurrent nursing shortage and physician surplus.

Changing technology. Technology has significantly changed both medicine and nursing. But while technology has fragmented medicine, it has given nursing more control over the healing environment.

Medicine has divided up the patient's body into episodic visits among its various specialists. In contrast, nursing has honed the skills of understanding, monitoring, and caring for the whole person around the clock. The physician may be legally "in charge" of the patient, but the nurse is the indispensable mechanism for managing most of the healing process—which often involves knowing whether and when to call in the physician's specialized expertise.

Nursing has honed the skills of...caring for the whole person around the clock. The physician may be legally "in charge" of the patient, but the nurse is the indispensible mechanism for managing most of the healing process....

The science of medicine, with its spectacular cures, has made crisis care the physician's treatment of choice, leaving the art of healing to the professional nurse.

Furthermore, the technology used by physicians to treat acute illness is neither very useful nor cost effective in treating subacute, cumulative, and progressive disease. And, now that medicine and society have successfully addressed so many major causes of acute illness, the focus for health care is fast becoming chronic and degenerative illness. Dramatic medical interventions can correct the effects of acute and chronic disease, but it is nursing technology that manages the entire environment in which care takes place.

Quality of care. Although aspects of nursing care have, in turn, been taken over by specialized technicians, nurses still have primary responsibility for managing care and monitoring its effects. In managed care systems, nurses have taken on the crucial role of ensuring that patients receive an appropriate level of care at all times, both inside and outside the hospital setting. Nurses are thus critical to ensuring the quality of care.

In fact, a recent *Hospitals* survey of 663 American hospital executives (see Quality Watch, p. 32, Feb. 5), found that nursing care is considered a more significant factor in providing high-quality care than the clinical skills of the medical staff—although those skills did rank a close second.

Expanding responsibilities. The *Physicians' Current Procedural Terminology*, a coding system published by the American Medical Association, designates physicians as the only providers of all coded services. Yet many of those services, once provided exclusively by physicians, now have a strong nursing component or are provided solely by nurses (albeit under physician direction or supervision).

Another example of expanded nursing responsibilities is the advanced cardiac life support certification course—created by physicians for physicians—that has become a standard requirement for critical care and emergency department nurses.

Nursing observation now includes internal aspects of patient care. Nurses monitor blood gases and chemistries, draw and measure blood sugars, measure venous and ventilator pressures, and track blood cultures. In many places, the need for an EKG is first es-

tablished by the nurse, who then interprets the results, decides on the appropriate action, and evaluates the patient's response.

Nurse anesthetists administer anesthesia and assist in the management and resuscitation of critical patients. Nurse midwives care for healthy pregnant women throughout the maternity cycle. Nurse practitioners have skills in physical diagnosis, psychological assessment, and the management of common health problems. They provide direct primary care and prescribe medications.

Policing physician practice. An individual physician's practice is increasingly policed by other physicians, the government, and the press. Peer review, utilization review, preadmission certification, managed care systems, published outcome statistics for comparable procedures, and malpractice litigation all influence how physicians in this country treat patients. And, chances are, the "middleman" with whom the physician must interface in this system of controls is a nurse.

Now that the courts hold hospitals accountable for the quality of physician practice within their walls, nurses have become hospitals' first line of defense in observing what is or is not being done for the patient's good.

Nurses are becoming the constables of the health care system. As such, their duties include reviewing length of stay, assessing the quality of care, and checking physicians' privilege credentials against physician-established criteria.

In a further move toward mechanizing medical practice, the American Medical Association is developing diagnostic-specific "practice parameters." While organized medicine will control what goes into the parameters, operation of the established parameters will be largely in the hands of nurses.

Supply and demand. Managers are faced with a glut of physicians as well as a shortage of nurses. As new young doctors find it more and more difficult to establish a private practice, they are choosing to become primary care physicians for group practices and managed care organizations. This phenomenon is dividing physicians into two adversarial groups: the physicians who, as gatekeepers, are rewarded for not providing care; and the physicians who are paid more for providing more services to patients.

The physician surplus has also stimulated the movement of patient care to alternative settings outside the acute care hospital.

Meanwhile, even though hospitals employ more nurses and have a higher nurse-to-patient ratio than ever before, we have a major nursing shortage.

The reality of this phenomenon is that nurses have done a very professional job of back-filling most of the vacuums left by advancing medical technology and specialization. Yet the health care system has failed to reckon with nurses' expanded, changing role.

Professional mobility. Physicians can move up in their profession and achieve success by gaining more and more expertise in patient care. But for the nurse, professional advancement has almost always meant giving up caring for patients—the very reason that the nurse went into nursing—and going into management instead.

Evidence suggests that the upward mobility issue will condemn health care to an ever-increasing nursing shortage. Yet, despite all warnings, organized medicine and hospital management are still trying to contain nursing in a box with a lid on it.

More handmaidens? The AMA's answer for the nursing shortage is to create a new, lower-level category of nurse—called the registered care technologist—who requires less training and has fewer skills than the registered nurse; who is employed by the hospital but accountable to the doctor; and who, like the RN, has nowhere to go in terms of career. To today's nurses, the AMA's registered care technologist appears to be a reincarnation of the original doctor's handmaiden.

Hospital management had better decide, and quickly, which side of this issue is in its best long-term interest.

The evidence tells me that nursing has a very strong argument for its case.

The demographics of this issue are quite similar throughout most of the developed world:

- There are not enough registered nurses to do all the patient care functions that medicine and management have come to expect of them.
- The post-World War II baby boom is over and the number of young people entering the workforce in developed countries will drop dramatically over the next 20 years.
- Women now have the opportunity to enter and succeed in almost any career—meaning that fewer will choose nursing in the future.
- The lack of a clearly identified professional career ladder in patient care is the number one reason why people leave or do not enter nursing.

New roles needed. In the face of the nursing shortage, it is foolhardy to even try to preserve the traditional demarcation between medical and nursing roles in patient care. In fact, we should be helping the opposite to take place.

I don't for a minute believe that nurses will ultimately manage physicians. However, it is a concept that hospital management should allow itself to consider if it is to successfully cope with the changing roles and relationships of physicians and nurses.

Until we free our thinking as to how far things *could* go, we will be locked into all the old dogmas and unable to exercise the leadership necessary for what looms ahead in health care delivery.

Consider what will happen over the next 10 years:

- By 1995, more than 60 percent of all surgical procedures will be performed in an ambulatory setting.
- By the year 2000, less-invasive surgical and diagnostic technologies will require an entirely different generation of health care facilities.
- Computer-assisted diagnostics will become directly available to patients, resulting in fewer physician visits.
- By the year 2000, many areas of the world will be awash in an oversupply of physicians.
- Nurses will provide the primary care for the burgeoning mass of chronic and degeneratively ill patients.
- The medical staff structure as we know it will have eroded, existing referral mechanisms for specialists will have all but disappeared, and most practicing physicians will be on salary.
- Computers will finally liberate nurses and physicians from the paper chain that consumes so much valuable time.
- Upwardly mobile career nurses will function in place of house staffs to replace residency training programs in specialties already oversupplied with physicians.

We must create a professional patient care career ladder for nursing that... defines the education, training, and credentialing process by which a nurse can qualify for increased levels of patient care authority....

The successful hospital manager for this new era will have acknowledged and dealt with the artificial limits frustrating nurses today, as well as medicine's resistance toward its rapidly changing environment.

What to do. The various forces dynamically changing the roles and relationship of physicians and nurses are evolutionary; there is very little we can do about them. But we can do a lot *with* them, and we had better start now.

For starters:

- We must recognize that most nurses enter and want to stay in nursing to care for patients.
- We must admit that our current system thwarts good nurses from building a career around caring for patients.
- We must create a professional patient care career ladder for nursing that starts with entry-level requirements and defines the education, training, and credentialing process by which a nurse can qualify for increased levels of patient care authority and responsibility up to, but not including, that of a medical doctor.
- In the same way nursing has assumed redundant duties from medicine, we must aggressively move to free professional patient care nurses from the depressing burden of nonpatient care activities. This can be done through more effective use of technicians, nurse aides, and computerized information and record systems.
- Finally, we must realign the role relationships of physicians, nurses, and technicians in the hospital setting. For the best patient care, these roles must be complementary, not adversarial.

Using American football parlance, the physician should be seen as the coach, the nurse as the quarterback, and technicians as the specialists in the backfield. The physician/coach is clearly responsible for deciding on the objective and calling the plays. The nurse/quarterback has the skills and authority to execute the physician/coach's instructions, and to modify those instructions up to certain qualified limits, based upon what is happening at the time. Success depends on each team member understanding and respecting the special contribution made by other team members. This is called *teamwork*—and it works.

Hospital management must get off the fence and stop trying to just get by while all the world around it is in the chaos of change. Viable, effective patient care, and the successful operation of the hospitals in which it is delivered, requires that we help to build a bridge between nursing and medicine. We must step out as leaders in creating new, more satisfying roles and relationships for medical and health professionals in the 21st century. H

Judith Haffner

February 21, 1990

Senate Insurance Committee
Capitol Building
Topeka, KS 66612

Dear Senators:

El Dorado Butler Co.

I am an Advanced Registered Nurse Practitioner with my area of specialty being Surgery, Emergency and Trauma. I obtained my advanced nursing status in 1979 and worked in an emergency room setting from 1977 to 1981. I was required to have my registered nurse education plus two years of experience in a specialty area (which is surgery, emergency and trauma) plus physician sponsorship prior to even entering the Nurse Practitioner program. Yes, I am Board Certified. I work with the only Board Certified Surgeon in our county (another board certified surgeon has established his office on the outskirts of the county, approximately 30 miles from our town and neighboring a large city where he performs his surgery in another county). I have had numerous post graduate educational experiences including attendance at the "New Horizons in Surgery Conference", The American College of Surgeons National meetings, "The American College of Surgeons Committee on Trauma". These meetings are all on a yearly basis. In addition to this, I also attend Nursing Conferences and I am scheduled to be an instructor for the yearly Kansas Advanced Nursing Conference to be held this spring in Salina, Kansas.

As an Advanced Registered Nurse Practioner in my role, I perform history and physicals, assist my surgeon in the operating room on select cases on a daily basis, make both pre and postoperative rounds in the hospital on a daily basis, do discharge summaries, and see patients in the emergency room. For example, in our rural setting, if the surgeon and I are in surgery, the surgeon definitely does not leave the surgical suite. In a critical or life threatening situation occurring in the emergency room, I can break my surgical scrub and triage the emergency trauma problem. This is important in helping supply excellent surgical trauma care in our rural setting in our area. To be unable to provide this service would necessitate at least a 45 minute to one hour drive on a highway to the nearest larger community plus at least a 15 to 30 minute inner city drive to the nearest emergency room. This costs dearly in fees for emergency transport-tation submitted to the insurance companies. Time, facility, and also of utmost importance, a well educated, trained professional can respond immediately saving significant sums of money for the insurance companies. Trauma and lack of experienced professionals cost money.

Through my education, my knowledge of anatomy and physiology, and my clinical experiences, I feel comfortable with the responsibilities that I accept. As an A.R.N.P., I also know the realm of my practice. In helping prepare a patient for surgery, I spend 2 1/2 to 3 hours teaching the patient and their family preoperative, intraoperative, and postoperative care. On occasions I do make house calls to check on patients that are unable to transport themselves to the hospital. The time spent with our patients can statistically show better prepar-edness, preoperative as well as a smoother postoperative recovery phase and shorter hospitalization stay. If any of the members of this committee have been

Attachment 6
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hospitalized or had surgery in the past few years then I am sure you are aware of the push by third party reimbursement companies to have early dismissals thinking that this saves money. This saves dollars for the insurance companies, but puts significant strain on the patient and their families. A great number of our patients are elderly. Smooth, knowledgeable assisting, helps facilitate the entire health care system with shorter anesthesia time, shorter postoperative recovery time, shorter hospitalization stay, meaning less reimbursement funding for the companies.

With the push to request patients to leave early to comply with "their insurance contract", this does definitely put a strain on the patient. I am helping to alleviate that strain. Shorter, smoother recovery phase, plus shorter stays without the use of extended care facilities or nursing homes or home health care facilities, are saving the funds the insurance companies want. But, while I am trying to help the patient, I am not acknowledged by third party reimbursements, nor can I collect for this. Again, I state that a great deal of our patients are elderly and they need this service greatly. On a daily bases I reflect on this and worry about who will help us when we are in need of this care in the future.

For only a few short months in 1989 did my employer receive third party reimbursement for my services. The patients seemed very satisfied with their care. This year my malpractice premium is $2000.00 as an A.R.N.P. in my role. I have never had a claim against me. The malpractice Insurance Company that I am with acknowledges my role and understands my role and considers my role to be appropriate. They seem to feel that it is worth the $2000.00 fee. I think my role is worth acknowledgement and reimbursement to help supplement the cost of this. To generate my salary and help cover the exense of my malpractice premium, I urge you to please consider third party reimbursements for A.R.N.P's.

Again, I am in a rural setting, on call 24 hours a day to help give continuity of excellent surgical care. I consider myself a professional and respect the role as such. Without legislative support our role will adversely affect the much needed population. Objectively, this can be viewed in many settings. I would seriously appreciate your support on this upcoming legislation regarding Senate Bill 633.

Thank you for your anticipated attention and concern. If you have any questions please feel free to call me at home or at my office number.

Sincerely,

Judith Haffner, A.R.N.P.

JH/kh

H - 1-316-321-4661

W - 1-316-321-5630

6-2

kaanp

Kansas Alliance of Advanced Nurse Practitioners

TO: Senate Insurance Committee

FROM: Mary Jane Whelan, R.N.,C., A.R.N.P.

DATE: February 22, 1990

SUBJECT: SENATE BILL No. 633

Senator Bond and members of the Committee, thank you very much for the opportunity to appear before you today. My name is Mary Jane Whelan, I am an advanced registered nurse practitioner from St. Paul, Kansas. I am Vice Chair of the Kansas Alliance of Advanced Nurse Practitioners.

Nurse practitioners are registered nurses who have advanced education and clinical training. We practice under the rules and regulations of the Kansas Nurse Practice Act. Nurse Practitioners provide primary health care in a variety of settings, both rural and urban. Primary health care is defined as the prevention of disease, promotion and maintenance of health, assessment of needs, long term nursing management of chronic illness and referral of clients to other resources.

Health care needs are of major concern to Government, health care professionals, and consumers. Accessibility of care is crucial, and is often lacking in rural areas. The result is, health status of rural Americans remains significantly lower than that of urban Americans.(1)

The 1988 Kansas Medically Underserved Areas Report", surveyed the number of medically underserved counties in Primary Care from 1984 to 1988. The survey showed that there was a steady

Attachment 7
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2/22/90

increase in "Critically Underserved" counties between this period. In 1988, there were 7 " Underserved Counties", and 58 "Critically Underserved Counties." The number of "Critically Underserved Counties" increased by 6 from 1987 to 1988.(2)

This indicates a major gap in primary care in rural areas of Kansas. Nurse practitioners can provide a significant percent of this care. Nurse practitioners have historically played valuable roles in furnishing access to health care in rural areas. In testimony given before the Kansas State Board of Nursing by Lynetta Handshy in 1988, a map showing the distribution of nurses in advanced practice in Kansas was presented. 58% of practitioners lived in towns with a population of less then 20,000.(3)

Utilization of and reimbursement for, mid-level practitioners to do histories and physicals, pre-employment and insurance physicals, health maintenance, chronic disease monitoring, and management of simple acute illness and injury as is allowed by Kansas law, will not only serve to fill the gap, but will encourage professionals to enter this much needed field.

Nurse practitioners provide quality care, and are cost effective. According to The American Academy of Nurse Practitioners, studies shows that the quality of care provided by nurse practitioners is as high as the care rendered by physicians for that range of skills which the nurse practitioners are trained to use, and that nurse practitioners rate high in consumer satisfaction.(4)

kaanp

Kansas Alliance of Advanced Nurse Practitioners

Reimbursement to nurse practitioners has shown to be cost effective. Studies concerning nurse practitioners, health insurance and cost effectiveness show that third party payment plays a major role in meeting the costs of health care in the United States. Present insurance reimbursement practices favor costly hospitalization and physician care. Effective utilization of Nurse Practitioners has the potential to increase access to health care, to increase efficiency in its provision, and to provide cost-saving.(5)

The proceedings of the Kansas Rural Health Policy for the 90's Working Group held in the State House on September 14, 1989, brought together 31 leaders from across the health care spectrum. Two of the identifiable problems in terms of health manpower shortage were; A critical shortage of nurses, and **a need for more equitable reimbursement for rural health care providers.**

There is major consumer group support for nurse practitioners in Kansas. Farm Bureau of Kansas stated in June of 1988 that it supports greater use of non-physician providers to help relieve personnel maldistribution in the medical profession.(6)

I ask for your support of S.B. 633. We only seek reimbursement for services that historically have been provided by nurse practitioners. It is most probable that health care in Kansas will continue to suffer due to poor physician distribution. It has been documented that nurse practitioners provide high quality, cost effective care, and that we are well accepted by major groups and individual comsumers. Third party reimbursement will serve to utilize nurse practitioners in primary care and will increase accessibility of health care for rural Kansans.

kaanp

Kansas Alliance of Advanced Nurse Practitioners

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2. Budig, Gene A., Chancellor and Clawson, D. Kay, M.D., Executive Vice Chancellor; University of Kansas Medical Center; THE 1988 KANSAS MEDICALLY UNDERSERVED AREAS REPORT, in conjunction with the Kansas Medical Scholarship program. December 31, 1988: See Attachment.

3. Handshy, Lynetta, submitted during testimony before open hearing of the Kansas State Board of Nursing: See Attachment.

4. American Academy of Nurse Practitioners: NURSE PRACTITIONERS, DOCUMENTATION OF QUALITY OF SERVICE: See Attachment.

5. American Academy of Nurse Practitioners; NURSE PRACTITIONERS, DOCUMENTATION OF COST EFFECTIVENESS: See Attachment.

6. Reinhardt, Linda; Kansas Farm Bureau; "BEND THE TREND, MEETING THE NEEDS OF THE RURAL ELDERLY." SELECT COMMITTEE ON AGING, FIELD HEARING; Pittsburg, Kansas, June 13, 1988: See Attachment.

SELECT COMMITTEE ON AGING

FIELD HEARING

Pittsburg, Kansas
June 13, 1988

Statement of the Honorable Jan Meyers, U.S. Representative, Third District, Kansas

One of the most urgent needs facing Kansas and the nation is rural health care. As a Kansan, a Member of the House Select Committee on Aging, and as a concerned citizen, it is a privilege to be here today to address this vital issue. It is especially appropriate to be talking about rural health care in Pittsburg, Kansas rather than in Washington, D.C. It seems more fitting.

I think it is fair to say that there is a heightened awareness in Congress of the problems associated with rural health care—transportation, availability of services, costs, Medicare reimbursement rates, and availability of doctors and nurses.

As many of you know, the week of May 15 was declared "National Rural Health Awareness Week." The resolution states that:

- Rural Americans account for nearly 25% of the population, but are served by only 12% of the nation's doctors, 18% of the nation's nurses, and 14% of the nation's pharmacies;
- The resulting health status of rural Americans remains significantly lower than that of urban Americans, with rural Americans showing a disproportionately higher rate of maternal and infant mortality, injury, and chronic illness;
- Accessibility to the available health care services in rural America is limited not only by the lack of transportation, but also by the fact that more rural residents are uninsured;
- Closures of rural hospitals and other health care facilities, which have a severe impact on their communities, continue to spread across the rural areas of our nation.

Furthermore, several important provisions were included in the Budget Reconciliation Bill for Fiscal Year 1988. First, the bill authorized grants to assist small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services the hospitals provide in order to adjust to various changes. This planning could involve changes in service population, clinical practice patterns, demand for acute-care inpatient hospital capacity, ability to provide appropriate staffing for inpatient hospitals, demand for

ambulatory and emergency services, and demand for appropriate integration of community health services. The President recommended funding for this program in FY'89; the Appropriations Subcommittee on Health has yet to report its recommendations. We should know what this recommendation is in a few

The Reconciliation Bill created an office of Rural Health Policy within the Department of Health and Human Services. Its charge is to coordinate all rural health care issues and be a voice for further reforms and innovative approaches. It should be a real advocate for rural America.

A physician in a rural health care manpower shortage area will get an additional 5% repayment in addition to the Medicare repayment. It also increased the reimbursement for rural health clinics from $32.19 per visit maximum to $46.00. Furthermore, psychologists' services in rural mental health clinics are made reimbursable, and direct reimbursement is authorized for psychologists' services furnished at community mental health centers.

Another important provision requires Peer Review Organizations to take into account special problems associated with delivering care in remote rural areas, the availability of alternatives to hospitalization, and the distance from a patient's residence to the site of care. These are important steps, but the efforts must continue.

EXECUTIVE SUMMARY

In 1986, the Kansas Legislature amended K.S.A. 76-373 et seq., authorizing the University of Kansas Medical Center to annually determine medically underserved areas in Kansas by physician specialty. Using data from the Board of Healing Arts' 1988 Physician Licensure Renewal Survey of medical and osteopathic doctors, the University of Kansas Medical Center has determined medically underserved areas in primary, secondary, and tertiary care. The following tables summarize information from the 1988 medically underserved areas analysis, comparing the 1988 results with findings from past analyses. Changes in care status from previous reports are due to requested designation reviews.

Primary Care

A total of 65 counties were determined to be medically underserved in primary care in 1988, equivalent to the total underserved designations in 1987. Of the 65 counties, 58 of them were determined to be critically underserved, six more than were designated as critically underserved in 1987. The following table indicates the number of medically underserved and critically underserved counties in primary care from 1984 to 1988.

Table 1

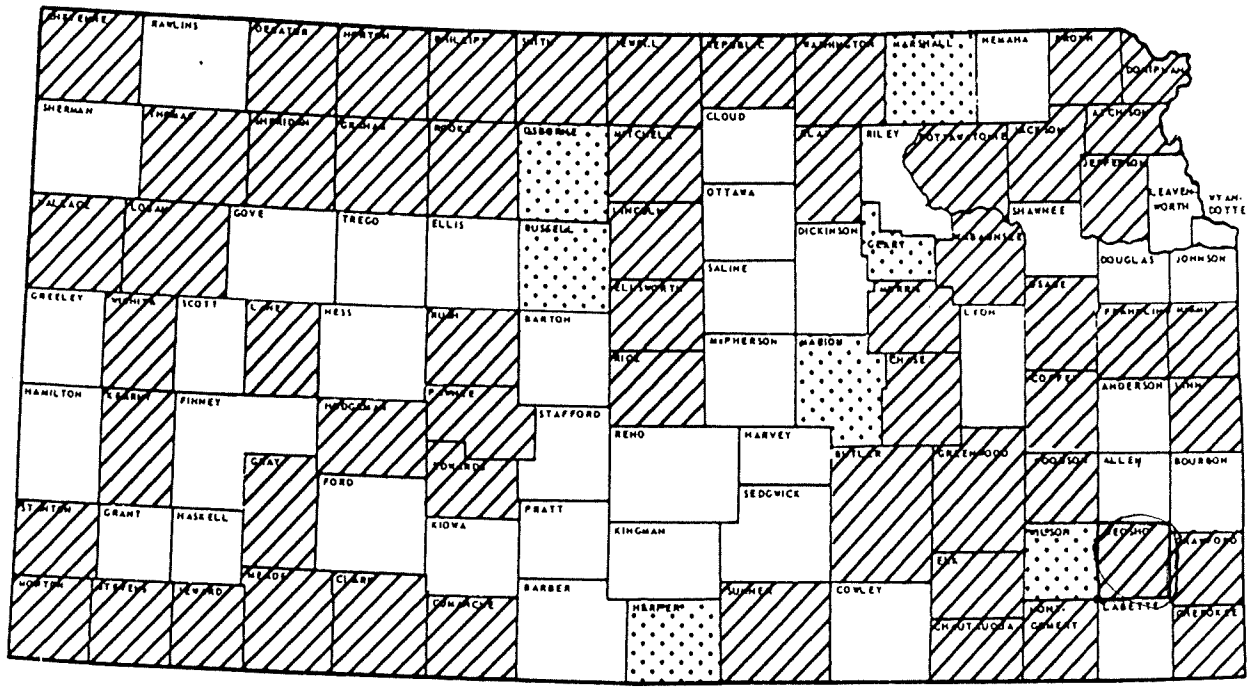
Number of Medically Underserved Counties in Primary Care
1984 to 1988

	1984	1985	1986	1987	1988
Underserved	16	10	5	13	7
Critically Underserved	30	42	46	52	58
Total	46	52	51	65	65

In 1988, the Chancellor's Advisory Committee on the Kansas Medical Scholarship Program approved a methodological revision to the procedures used to calculate primary care physician-to-population ratios. Prior to 1988, 0.5 FTE were deducted from total FTE for each county to compensate for the hypothetical loss of physician manpower. Requests for reviews of the 1987 primary care designations reached a record high of 25, compared to 15 for the previous period. Of these reviews, 13 were approved, many due to the loss of one or two physicians. In response to the apparent need for an allowance that more accurately reflected the communities' needs, the reduction was revised to 1.0 FTE in 1988. The total number of underserved counties in 1988 equals the total for 1987 after adjusting for changes to 1987 designations that were made as a result of the reviews during the past year. Although 12 fewer counties would have been designated as underserved if total FTE for each county had been adjusted by the 0.5 allowance in 1988, numerous reviews during the coming year would be expected to bring the total number of underserved areas close to the total shown above. With the increased adjustment it is expected that fewer designation reviews will be necessary during 1988.

PRIMARY CARE

1988 UNDERSERVED AREAS



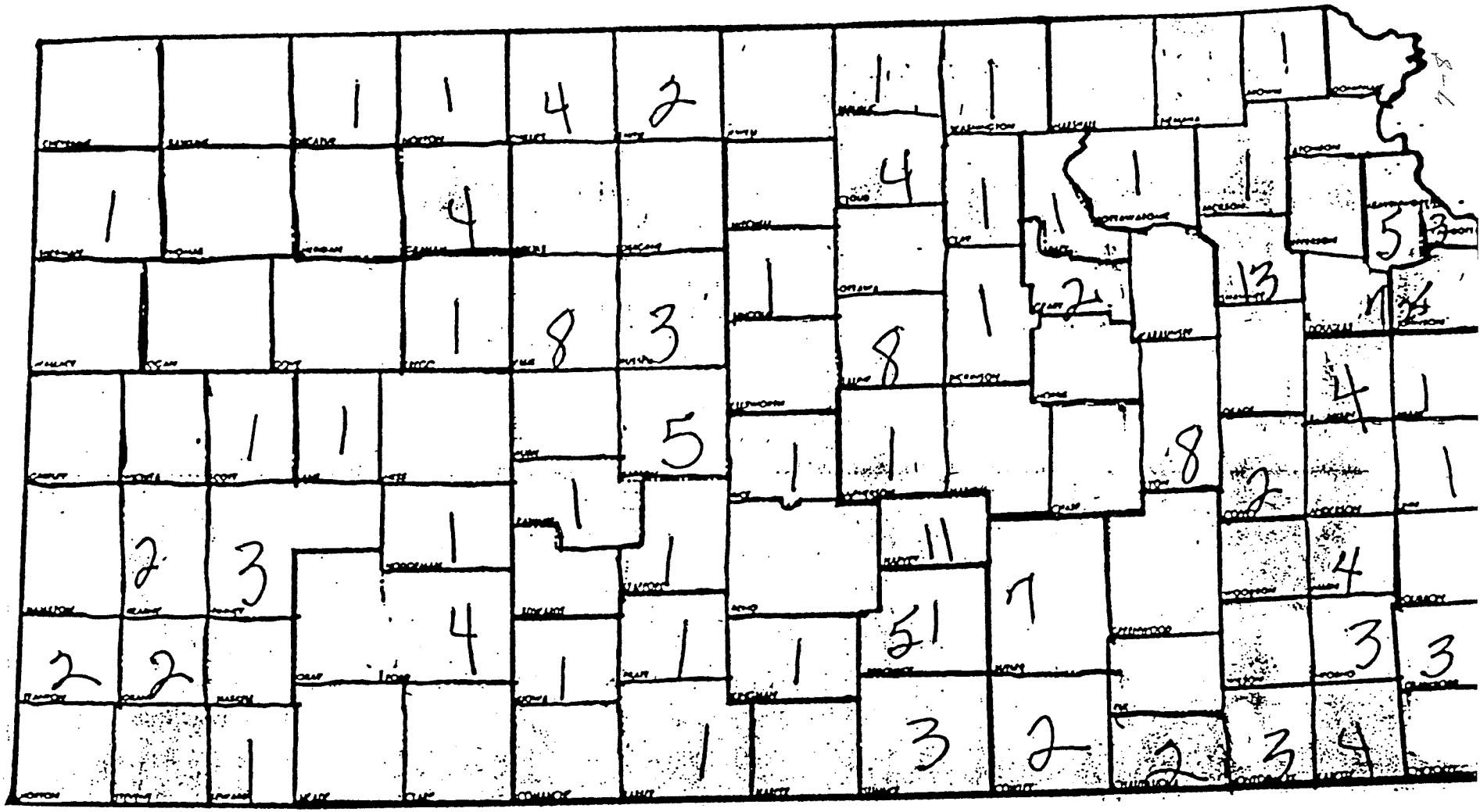
Specialties include: Family Practice; General Practice; Internal Medicine; Pediatrics

Atchison	CU	Franklin	CU	Marshall	U	Rooks	CU
Brown	CU	Geary	U	Meade	CU	Rush	CU
Butler	CU	Graham	CU	Miami	CU	Russell	U
Chase	CU	Gray	CU	Mitchell	CU	Seward	CU
Chautauqua	CU	Greenwood	CU	Montgomery	CU	Sheridan	CU
Cherokee	CU	Harper	U	Morris	CU	Smith	CU
Cheyenne	CU	Hodgeman	CU	Morton	CU	Stanton	CU
Clark	CU	Jackson	CU	Neosho	CU	Stevens	CU
Clay	CU	Jefferson	CU	Norton	CU	Sumner	CU
Coffey	CU	Jewell	CU	Osage	CU	Thomas	CU
Comanche	CU	Kearny	CU	Osborne	U	Wabaunsee	CU
Crawford	CU	Lane	CU	Pawnee	CU	Wallace	CU
Decatur	CU	Lincoln	CU	Phillips	CU	Washington	CU
Doniphan	CU	Linn	CU	Pottawatomie	CU	Wichita	CU
Edwards	CU	Logan	CU	Republic	CU	Wilson	U
Elk	CU	Marion	U	Rice	CU	Woodson	CU
Ellsworth	CU						

U - Underserved (7 counties) CU - Critically Underserved (58 counties)

Refer to page 7 for information on qualifying medical facilities.

Designation effective December 31, 1988 - December 31, 1991



Population dispersment of nurses in advanced practice in Kansas based on a list purchased from the Kansas State Borad of Nursing in August, 1988.

AMERICAN ACADEMY OF NURSE PRACTITIONERS
45 FOSTER ST., SUITE A; LOWELL, MA 01851 (508) 937-7343

Summarizing the findings of the numerous studies of nurse practitioner's performance in a variety of settings, the Congressional Budget Office concluded: Nurse practitioners have performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.[1]

Studies have shown that nurse practitioners rate high in consumer satisfaction.[2]

Review of studies comparing nurse practitioners and physicians led the Congressional Office of Technology Assessment to conclude: "NPs appear to have better communication, counseling, and interviewing skills than physicians have."[3]

The OTA study also states: "Malpractice insurance premiums and the incidence of malpractice claims indicate that patients are satisfied with NP care. Although insurance premiums for nurse practitioners are increasing, successful malpractice suits against them remain extremely rare."[4]

In a review of 26 studies comparing nurse practitioner performance to that of physicians, Prescott and Driscoll reported that nurse practitioners received higher scores than physicians on several variables. These included such areas as amount/depth of discussion regarding child health care, preventative health, & wellness; amount of advice, therapeutric listening, and support offered to patients; completeness of history and followup on history findings; completeness of physical examination and interviewing skills; and patient knowledge about the management plan given to them by the provider.[5]

In a review of 15 studies, Record concluded that between 75% and 80% of adult primary care services and up to 90% of pediatric primary care services could be performed by nurse practitioners.[6]

Productivity studies show that if a nurse practitioner is utilized efficiently, s/he could increase the productivity of a solo practice physician by approximately 70%.[7]

A review of several studies shows that the quality of care provided by NPs is as high as the care rendered by physicians for that range of skills which the NPs are trained to use. The quality of care comparison was measured by diagnosis, treatment, and patient outcomes.[8]

Robyn and Hadley report, ". . . it appears that patients respond favorably to the quality of treatment itself, as well as the tendency of nurse practitioners . . . to spend more time with them, to create a more relaxed atmosphere in which they (the patient) feel more comfortable asking questions which they might regard as too trivial for a physician.[9]

The Burlington Randomized Trial Study found that nurse practitioners made appropriate referrals when medical intervention was necessary.[10]

Estimates of increases in the productivity of physician practices that include nurse practitioners range from 20 to 90 percent. The greatest increase in productivity results when the nurse practitioner has primary responsibilities for a subset of patients and refers complicated cases "up" to the physician rather than having the physician delegate routine problems "down" to the nurse practitioner.[11]

In the Burlington Randomized Trial Study, it was found that nurse practitioners were able to provide primary care services as safely and effectively as physicians.[12]

In a federal physician extender reimbursement experiment, it was found that physician/nurse practitioner teams provided a higher quality of care than physicians alone.[13]

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[13] System Sciences, Inc. **Nurse Practitioners and the Physicians Assistant Training and Deployment Study: Final Report** Contract No. HRA 230-75-0198. Bethesda, MD: System Sciences, Inc., September, 1975.

NURSE PRACTITIONERS

PROVIDERS OF QUALITY PRIMARY HEALTH CARE

DOCUMENTATION ON QUALITY OF SERVICE

AMERICAN ACADEMY OF NURSE PRACTITIONERS
45 FOSTER ST., SUITE A, LOWELL, MA 01851 (508) 937-7343

1) Sara Writson, in her review and analysis of studies concerning Nurse Practitioners, health insurance and cost effectiveness, reports: "Third party payment plays a major role in meeting the costs of health care in the U.S. Present insurance reimbursement practices favor costly hospitalization and physician care. Effective utilization of Nurse Practitioners has the potential to increase access to health care, to increase efficiency in its provision, and to provide cost-savings."[1]

2) A 1980 study by CHAMPUS to determine the cost effectiveness of direct, independent reimbursement to Nurse Practitioners showed that of the 44 procedures billed, 32 averaged 31% less than the amount normally allowed to cover physician bills. All but one of the bills for office visits were less than the allowance for a visit to a physician.[2]

3) In a review of 15 studies, Record concluded that between 75 and 80% of adult primary care services, and up to 90% of pediatric primary care services could be performed by Nurse Practitioners. Potential cost savings with the use of Nurse Practitioners was estimated at $0.5 billion to $1.0 billion or 19 to 49% of primary care provider costs.[3]

4) The 1975 study by Runyan showed that the use of Nurse Practitioners in decentralized outpatient medical clinics resulted in 50% fewer hospitalized days for their patients compared to the control group.[4]

5) Robyn and Hadley conclude in their analysis of health care costs that "movement away from a physician-dominated delivery system is essential if significant long-term cost savings are to result."[5]

6) A recent, unpublished study by System Science, Inc. of Bethesda, MD found that for 58 tasks grouped into 5 categories—Physical examination, office surgery, lab procedures, patient education and counseling—the average bill was $8.13 when performed by a Nurse Practitioner and $16.48 when performed by a physician.[6]

7) Robyn and Hadley found, in their review of data, that the training of providers such as Nurse Practitioners, is approximately one-quarter to one-third the cost of training a physician. This is a savings that potentially could be passed onto the consumer in lower fees.[7] It has already been reported that Nurse Midwives charge slightly less than obstetricians for their services.[8]

8) Another study found that, for two sites served by ambulatory clinics staffed by Nurse Practitioners . . . utilization of hospitals (number of admissions and duration of stay) was lower than for two matched control sites without clinics with Nurse Practitioners.[9]

9) Case in point: "Ms. A [who has had a stroke] . . . lived on a fixed income, and a visit to her physician for a minor problem would have cost $100.00 for ambulance fees alone . . . [The visiting Nurse Practitioner's] last physical exam revealed a monilial [yeast] infection . . . The Certified Nurse Practitioner's telephone call to the physician produced the necessary prescription, and an expensive office visit was averted.[10]

10) An article reviewing the studies of non-physician health care professionals concludes that four such non-physicians can replace two or three physicians. Adding a non-physician health care professional produces an average increase of 40 to 50% in total office visits. Replacement of a physician by a non-physician health care professional produces cost savings of more than $34,000 a year.[11]

11) In a study by Salkever and other comparing the treatment of otitis media and sore throat, it was found that services provided by Nurse Practitioners were less costly than those provided by physicians.[12]

12) A study of third party reimbursement of Nurse Practitioners in Maryland and Oregon found in both states that Nurse Practitioners were charging less than physicians for their services.[13]

References

[1] Writson, Sara "Nurse Practitioner Reimbursement" **Journal of Health Politics, Policy and Law,** Vol. 6, No. 3, Fall 1981. p 444.

[2] Johnson, Jean "The Champus Hoopla . . . or Where have all the NP's Gone", **Nurse Practitioner,** Vol. 7, No. 6, June 1982, pp. 8-9.

[3] Record, J. C. (Ed.) **Provided Requirements, Cost Savings and The New Health Practitioner in Primary Care: National Estimate for 1990** Contract 231-77-0077. Washington, D.C.: DHEW, 1979.

[4] Runyam J.W. "The Memphis Chronic Disease Program: Comparisons in Outcome and the Nurse's Extended Role" **JAMA** Vol. 231, No. 3, Jan 20, 1975. pp 264-267.

[5] Robyn, Dorothy; Hadely, Jack "National Health Insurance and the New Health Occupations: Nurse Practitioners and Physicians Assistants" **Journal of Health Politics, Policy and Law,** Vol. 5, No. 3, Fall 1980. p465

[6] Writson, Sara "Nurse Practitioner Reimbursement" **Journal of Health Politics, Policy and Law,** Vol. 6, No. 3, Fall 1981. p445.

[7] Robyn, Dorothy; Hadley, Jack "National Health Insurance and the New Health Occupations: Nurse Practitioners and Physicians' Assistants" p. 448.

[8] Griffith, H. M. "Strategies for Direct Third Party Reimbursement for Nurses" **AM.J. of Nursing** 1982 March 82(3) p. 410.

[9] Robyn, D., et al "National Health Insurance and the New Health Occupations: Nurse Practitioners and Physicians' Assistants." p. 451

[10] Kendrick, Valen "Nurse Practitioner in a VNA" **Adm. J. of Nursing** 1981 July p. 1362

[11] Elaine Poirier Elliott, in **Nurse Practitioner,** October, 1984.

[12] Salkever, D.S. Skinner, E.A., Steinwacks, D.M. et al., "Episode-Based Efficiency Comparisons for Physicians and Nurse Practitioners" **Medical Care** 20(2), pp 143-153, Feb 1982

[13] Griffith, H.M. "Implementation of Direct Third Party Reimbursement Legislation for Nurssing Services" **Nursing Economics,** 1986 Nov-Dec, Vol. 4, No. 6, pp. 301-302.

NURSE PRACTITIONERS

PROVIDERS OF QUALITY PRIMARY HEALTH CARE

DOCUMENTATION OF COST EFFECTIVENESS

Testimony of Linda Reinhardt, Member-At-Large of the Kansas Farm Bureau Board of Directors, Manhattan, Kansas

I am here today representing the more than 126,000 member families of the Farm Bureau in Kansas. We want to bring to your attention some of the special needs of the rural elderly. Those needs are in a number of areas, some of the most pressing of which are health care, transportation, taxation and Social Security.

For many of our elderly, nursing home care will become a necessity. For others, remaining in their own homes will be a far preferable option. We believe health care programs should maximize the independence of the elderly for as long as possible.

In health and nutrition many things are needed. I will highlight but a few. We support:

- Legislation to allow 100% federal income tax credits or tax deductions for those who self-finance their health insurance.

- Greater use of non-physician providers to help relieve personnel maldistribution in the medical profession.

- Efforts of medical schools to train additional qualified family physicians who intend to practice medicine in rural areas.

- Economic inducements to encourage doctors to practice in rural areas. Along with the Kansas Medical Society, the Kansas Farm Bureau has initiated a program known as MEDISERVE. Our program provides financial stipends for candidates at medical school who will agree to practice in an underserved rural area of Kansas in one of the basic general practice/family practice specialties.

- State and federal government policies that provide incentives for medical and mental health services in rural areas.

- Efforts **at every level of government** to reduce medical malpractice insurance costs.

- Third-party payer recognition for payment of outpatient treatment and preventive measures.

While still on the topic of health and nutrition, I must say to you that we are **opposed** to compulsory national health insurance in any form.

Susan Hasselle, R.N., M.S.
346 MAINE
LAWRENCE, KANSAS 66044

(913) 841-1243
February 22, 1990

Senate Bill #633: Third Party Reimbursement for ARNP'S

Chairman Bond and Members of the Senate Financial Institutions and Insurance Committee:

My name is Susan Hasselle; I am a clinical specialist in psychiatric nursing. I obtained my master of science degree in psychiatric nursing in 1967, and have had numerous post-graduate educational experiences since then. I would like to make note that these post-graduate opportunities were made available to me with the understanding that my formal educational background was comparable to that of any of the other recognized mental health professionals. My educational qualifications were a prerequisite for my admission into these programs. My fellow students in all these post-graduate courses included: psychiatrists, certified clinical psychologists, certified psychiatric social workers. I would like to note that I am certified as an Advanced Registered Nurse Practitioner in Kansas. Since 1981, I have been working as a private practitioner at the above address doing individual, family, and marital therapy.

As a clinical nurse specialist in psychiatric nursing, I do offer quality care at a reduced fee in comparison to most psychiatrists and certified clinical psychologists. For example, my husband, who is a board certified psychiatrist, charges $80.00 for a fifty-minute psychotherapy/consultative session. I charge $50.00. Through the present date, I have been able to offer my clients the benefits of third party insurance coverage through several companies. As of January 1, 1990, however, Blue Cross/Blue Shield of Kansas terminated their direct reimbursement for my services. (An inconsistency is that M.C.C. of Kansas, after reviewing my credentials, does list me as a provider. My understanding is that Blue Cross/Blue Shield HMO of Kansas, as a cost cutting strategy, contracts with M.C.C. to provide services in Kansas.) Medicaid in the State of Kansas does not cover my services in private practice. When I am asked to see a medicaid client, I routinely refer them to my husband since psychiatrists are covered. The arithmetic documenting how much more this is costing the state of Kansas can

Attachment 8
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2/22/90

only be guessed at. Most clients and insurance companies, however, have commonly welcomed the option of pursuing quality psychotherapy through registered nurses with advanced preparation such as I. In this day of burgeoning medical/psychiatric costs, it is a refreshing discovery to have the option of choosing a therapist with reduced fees, knowing that most comprehensive insurance policies only cover a percentage of psychotherapy bills. Most of the referrals that I get, however, are not because of my lower fees. My referrals come from my reputation as a therapist, and I am the therapist of choice for my clients.

If the termination of reimbursement for mental health services for advanced psychiatric nurses by the largest health insurance company in the state forecasts a trend for the future, I'm left to assume that clients will no longer feel free to exercise their free choice in who they wish to see for a therapist. I believe this is a grave injustice to the health care consumers.

At this point in the state of Kansas, only those individuals licensed under the Board of Healing Arts and the Behavioral Science Regulatory Board are mandated by law to be reimbursed. Nurses in expanded roles are the only health care providers of currently covered mental health services which are not regulated by the above named boards. Nurses are licensed and certified for advanced practice by the State Board of Nursing. At a time when there is a shortage of qualified nurses and a need to attract new people into the profession, it is discouraging for potential candidates to witness this discrimination. Nurses need incentives if they are to expand their capabilities and still stay in the profession. This shortage is particularly critical in rural areas of Kansas where nurses may be the most accessible professionals in not only mental health, but in general health fields.

Thank you for allowing me to testify on this matter. If I can answer any questions or provide any further information, please feel free to call upon me.

February 21, 1990

Micki K. Zenger, CFNP
Rt. 1, Box 9
Haddam, KS 66944
(913) 778-3363

Senator Richard Bond, Chairman
Senate Insurance Committee
Capitol Building #128-South
Topeka, Kansas 66612

Chairman Bond and members of the Senate Committee of Financial Institutions & Insurance,

I am an Advanced Registered Nurse Practitioner and presently practice in and administer a Rural Health Clinic. This clinic has been in operation for over three years. Up until January, 1990, I was able to offer my patients the benefits of third party insurance reimbursement from several insurance companies, including Blue Cross and Blue Shield. Medicare and Medicaid still reimburse me for my services, and expect to continue to do so.

Many of my patients have coverage through Blue Cross and Blue Shield and were notified by letter that as of January, 1990, a rider was added, without their consent, to their policies stating that RN services were no longer covered. This rider did not specify that this would affect Nurse Practitioner services, such as mine. I now have to explain to patients that their insurance company no longer will make reimbursement for my services. I cannot explain why.

Quality health care and cost effectiveness are a top priority for everyone. I believe the quality and cost of my services are unquestionable. Limiting access to health care providers should not be a result of an attempt to cut costs. This new benefit reduction by third party insurance companies adversely affects effective employment of advanced nurse practitioners, such as myself, and limits patients' choices, resulting in decreased access to health care.

Rural Kansas is in a health care crisis and Senate Bill No. 633 must be passed to oblige insurance companies to pay for services provided by Nurse Practitioners. The result will be increased access to health care by those who have the least means to seek care elsewhere. I trust that you are also concerned about this problem and support this bill to provide a solution to this problem.

Sincerely,

Micki K. Zenger CFNP

Micki K. Zenger
Certified Family Nurse Practitioner

Attachment 9
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Carla Le

Dear Chairman Bond and Committee members:

Thanks for this opportunity to address each of you concerning the interests of supporting the concept underlying SB 633 delineating the provisions of providers of health services to be reimbursed, i.e. amending KSA 40-2, 19. I wish to share some history regarding the role development of ARNPs as well as some current practices in 3rd party pay within the state and within the role.

Kansas has been a forerunner in the nation with regard to role development for advanced practice addressing concerns formally as early as the 50s through a study sponsored by KSNA on nursing supply and services. In the mid-60s through grants of the Kansas Regional Medical Program, leadership of Dr. Brown and others, and the legislature, major strides were accomplished in establishing mid-level health practitioner programs, addressing rural care, medical maldistribution, library resource and funding issues. Additionally, KU opendd its masters-level program as early as 19(In the 70s, much progress was made as the state prepared an official health care plan, includuing specific statements for the utilization of nurse clinicians in urban clinics rural sites, and the health depts. Additionally, med school enrollments were increased a locum tenens program established, but need for mid-level health practitioners has continued with medical maldistribution continuing.

Specifically, as early as 1967 studies were done to address changing the NPA to expand the scope of practice of nursing, committees appointed to define expanded role between 1969 and 71, establishment of a nurse practitioner grant in 1969, program initiation in 1971 as certificate for nurse clinicians, formation of a state conference group for advanced practitioners by 1972. The NPA was revised in 1975 thanks to intensive work of legislature to make laws congruent with the national movement to utilization of mid-level health practitioners. Statutory authority for ARNPs was approved and rules and regulations for definition of practice, approval of educational programs, and functions or scope of practice for the types of ARNPs developed. Four categores exist in Kansas: nurse anesthesists, midwives, practitioner/clinicians and clinical nurse specialists. Permanent regulations were operational by 1982.

Numbers are important in Kansas considering the level of funding. Approximately 300 nurse practitioners were prepared for a role focusing upon health assessment, maintence of health, monitoring of chronic diseases, practice settings mostly in rural sites and urban underserved, i.e. community health clinics, private offices, physican group practices. One program prepared graduates for 60 counties of Kansas, 28 states (fed. funds) and 2 foreign countries(missions). A profile of the graduates included post-RN program with average years of experience of 10, age 40 on admission, primarily female, and 60% with some degree preparation. Programs nationally have usually ranged from 1 to 2 years, post-graduate study. Advanced role preparation has usually included preceptorships in community settings and with physicians in primary care practice or specialty areas for clinical specialists.

General progress for accomodation of this type of practice is acknowledged in the multiple clinics and physicians accepting educational roles and employing graduates. Hospital privileges for practice were obtained as early as 1972 in several settings. Prior to this, nurse anesthesists were practicing in expanded roles in hospital anesthesia services or with privileges. Kansas, after completion of the laws, now has, according to most recent State Board of Nsg. Annual Report, as certified 183 ARNPs, about .008% of liscensed nursing population, and 331 RNAs. Nationally, there are approximately 62,000 certified nurses in the 1.4 million RNs, with Kansas having 502. Of these, 135 are nurse practitioners, 30 psy specialists, and 61 clinical nurse specialists. These available, credentialed people can provide valuable

Attachment 10
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and cost-effective services, noting that this is not an overwhelming numbers to be considered for individual non-physician provider numbers, such as is possible for consideration under policy of services provided by non-physicians. It is important to also note that many ARNPs function in employer/employee (type B) situations versus type A provisions, i.e. independent practice.

Specifically regarding the concept of 3rd party pay, I wish to note this is not new and in this arena Kansas is not a forerunner, although major companies have since about 78 provided voluntary assignment through type B services or on individual consideration. Nurse anesthesists and private duty nurses have been approved for years. The need for consideration of non-physician reimbursement have been directed by same concerns as above: increased costs of care and need to change responses, shifts in the health care needs of the population, and major increase in vulnerable population, i.e. urban poor, rural, aging, maternal/child. It is estimated that 188 millions are covered by general private forms of insurance (84) of population, with 16 million in the older population supplementing medicare coverages. It is estimated, there are @ 21 million adults and 7 million children that are underinsured or uninsured, even with consideration of Medicare.[2] Nurses in expanded roles have been utilized to respond to such needs since the 30s in community health settings, as private duty and home nurses, and in multiple health clinics in 40s-60s. Nurse anesthesist association was founded in 1931. It was not until mid-60s that the nurse practitioner educational programs, mostly on federal dollars,were formalized. Initial development occurred in the military and by federal grants.

Coninciding with the development were major shifts in reimbursement patterns for nurse practitioner providers, i.e. child screening clinics, community health certification, CHAMPUS program, 1974, approving nurse reimbursement, Medicare and Medicaid, 1985, and Rural Health Clinic legislation, 1977.[3] Kansas has participated in this trend by reimbursement on selected basis for approved clinics in rural settings, placement of national health service corps trainees, some military clinics, and private offices on voluntary assignment basis. Also, the KSNA, through work of several advanced pracitioners, prepared resolutions as early as 1977.[4]

The 1989 Omnibus Bill, approved, has mandated state reimbursement programs for Medicare and Medicaid in states were the role in legally defined. Proposed legislation is in process for FEHBP(Federal Employee Health Benefits Program), the Community Nursing and Ambulatory Act, and the Advanced Nursing Services in Nursing Homes Act.

Regarding the scope of practice and legal authority for such practice, including transmittal of medications, a compilation of states is provided through the January, 1990, Nurse Practitioner Journal. Over 20 states are also listed that have Health Insurance Law Changes requiring Third-Party Reimbursement for services of nurses, mostly as nurse anesthesists, nurse midwives, and psychiatric nurses. Some have also included nurse practitioners for the private insurers. Federal reimbursement has been approved in special settings or specific populations since 1977.[5]

So, I wish to thank the legislators for all their efforts directed at various medical and health system crises, i.e. malpractice, rural and small hospital, community clinics, medical maldistribution, and expansion of nursing laws. All this work has made Kansas a leader in the national arena to effect the appropriate utlization of appropriately-credentialed advanced nursing practitioners in these needed areas. The voluntary system of approving specific nurses, such as nurse anesthesia, private duty, and some nurse practitioners, has been in practice since early 70s. Many of us have worked with the legislature to establish the PRACTICE laws and credentialing mechanims first. It is timely to now examine the health insurance laws specific to reimbursement. I thank you for this opportunity to share history and general practice items.

C. Lee, RN., C., ARNP, Ph.D.

10-2

1. Kansas State Board of Nursing, Annual Report, 1989.

2. H. Rowland, NURSES' ALMANAC, Aspen, 1984.(chpters on Health Costs & Insurance)

3. American Nurses Foundation, Inc. "Nurses in Private Practice,", ANA,1988.

4. KSNA, 1977 Resolution on Third Party Pay, July 15, 1977.

5. "Legal Authority, Reimbursement and Prescrptive Authority for Advanced Practice by State," NURSE PRACTITIONER, January, 1990, V. 12, no. 1., p. 12.

See general outline of National Trends for Third-Party Reimbursement.

C Roe, M.D.
2-21-90

C. Lee

RESOLUTION ON THIRD PARTY PAYMENT

Submitted by the Kansas State Nurses' Association

WHEREAS, nursing care is an essential component of comprehensive health care, consisting of preventive health maintenance, diagnostic treatment, and restorative and preventive services, and

WHEREAS, it is in the public interest to provide to all people unrestricted access to nursing services, and the nursing profession bears primary responsibility for guaranteeing to all people unconditioned access to nursing services, and

WHEREAS, access to nursing services is currently severely restricted by reimbursement policies and procedures used by public and private third-party payers for reimbursing consumers and providers, and

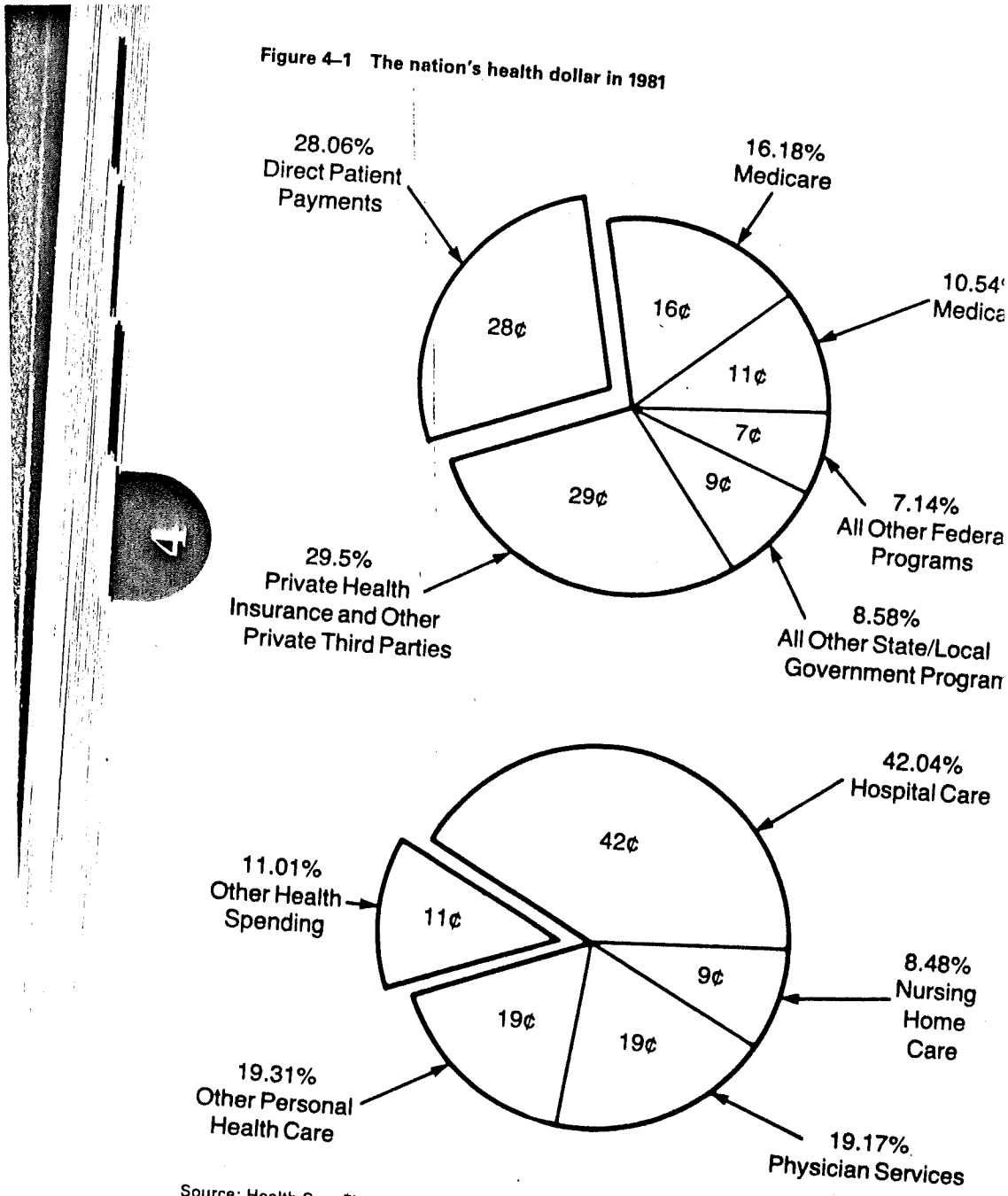
WHEREAS, among the autonomous licensed health professions only nursing is denied direct insurance reimbursement for its services, and

WHEREAS, this discriminatory practice jeopardizes public well-being and exploits professional practitioners, therefore be it

RESOLVED, that the first *Kansas State Meeting for Women* pursue all avenues at federal and state levels to effect unconditional recognition of direct fee for services reimbursement for nursing practitioners by both public and private third party payers.

15/July/77

Figure 4–1 The nation's health dollar in 1981



Source: Health Care Financing Administration, *Health Care Financing Review*, Fall 1983.

tered Nurses Certified by the Councils ertification of Nurse Anesthetists, January 1985

ber	State or territory	Number
74		
79	Montana	50
26	Nebraska	179
21	Nevada	31
2	New Hampshire	66
7	New Jersey	288
3	New Mexico	109
7	New York	673
8	North Carolina	740
3	North Dakota	123
9	Ohio	808
	Oklahoma	223
	Oregon	134
	Pennsylvania	1,529
	Puerto Rico	38
	Rhode Island	56
	South Carolina	286
	South Dakota	128
	Tennessee	541
	Texas	1,227
	Utah	56
	Vermont	33
	Virginia	449
	Washington	233
	West Virginia	251
	Wisconsin	316
	Wyoming	32
	National	37

etists, 1985.

Table 1.42. States That Have Adopted Legislation Authorizing Prescription of Drugs by Nurses, 1984

State	State
Alaska	New Hampshire
Arizona	New Mexico[2]
Florida[1]	North Carolina
Idaho	Oregon
Maine	Pennsylvania
Maryland[2]	South Dakota
Massachusetts	Tennessee[1]
Michigan[3]	Utah
Mississippi	Vermont[2]
Nevada	Washington

[1]Legal authority has not been implemented.
[2]Authorization is through the board of nursing rules.
[3]Authorization is through opinion of the attorney general.

SOURCE: American Nurses' Association, Center for Research, special tabulation from files of the Policy Analysis unit.

Table 1.43. States That Have Adopted Health Insurance Law Changes Requiring Third-Party Reimbursement Legislation for Services of Nurses, 1984

State	State
Alaska[1]	Montana
California[2]	New Jersey
Connecticut	New Mexico[1]
Florida	New York
Maine	Oregon
Maryland	Pennsylvania[1]
Minnesota[3]	Utah
Mississippi	Washington
	West Virginia

[1]Includes nurse midwives only.
[2]Includes psychiatric nurses only.
[3]Includes nurse anesthetists and nurse midwives only.

SOURCE: American Nurses' Association, Center for Research, special tabulation from files of the Policy Analysis unit.

10-6

NATIONAL TRENDS IN THIRD PARTY REIMBURSEMENT

The concept of the Advanced Practice Nurse is sanctioned by both state and federal legislation. The following list provides examples of such actions:

California reimburses private duty nurses and nurse anesthetists under state law without requiring physican supervision.(1)

Maryland law mandates health insurance compaines to pay for the services of nurse midwives and nurse practitioners without requiring physician intervention.(2)

Mississippi nurse practitioners and nurse midwives receive reimbursement for the services they provide in non-profit clinics with joint protocols for physicians and nurses.(3)

In Dec. 1984 New York State's bill for reimbursement to registered professional nurses in non-institutionalized practice was passed.

Washington State Medical Assistance Program reimburses services of nurses who are ANA certified. Also, since 1973 legislation mandates that disability and rehabilitation insurance policies reimburse for care provided by a registered nurse.

The Rural Health Bill, H.R. 8422, was passed and signed into law on December, 1977. This bill covers services performed by a primary care nurse practitioner in rural clinics.

Medicare reimburses services of registered nurses and licenses practical nurses for home health care in areas where there are not home health agencies.

Twenty-six states reimburse for nurse practitioner's services via Medicaid Title XIX when those services are submitted under a physician signature.(4)

CHAMPUS - P.L. 97-114 or the Champus (Civilian Health Care and Medical Program of the Uniformed Services) allows for direct reimbursement of certified nurse practitioners and nurse midwives without the supervision of physicians.(5)

Vermont's psychiatric nurses with an M.S.N. have been included with psychiatrists and licensed psychologists as "licensed mental health professionals" and the Secretary of the Agency of Human Services has instructed third party payers to reimburse for their services.(6)

In Wisconsin, services of masters prepared mental health nurses are reimbursed under Medicaid without the requirement of physician supervision.(7)

	Practice	Reimbursement	R
Indiana	NP practice is defined in NPA with qualifications "as determined by BON"; the BON has not yet adopted R&Rs.	NPs cannot directly receive third-party reimbursement.	No current legislative authority.
Iowa	Advanced-practice administrative rules are in the NPA. ARNPs are licensed by the BON.	There is legislation that permits third-party reimbursement for certified RNs.	No current legislative authority.
Kansas	Advanced practice recognition is voluntary for ARNPs (CNMs, NPs and clinical nurse specialists). There is mandatory recognition for CRNAs.	NPs can be reimbursed by Medicaid for assessment screening and for case management of technology-dependent children. Third-party payers reimburse CRNAs. There is no statutory requirement to reimburse ARNPs.	NPs may prescribe under jointly adopted protocols between the nurse and physician. The BON will adopt R&Rs for permanent regulations allowing for ARNPs to prescribe following jointly agreed upon protocols with "the responsible physician," excluding controlled substances.
Kentucky	State law licenses ARNPs (including nurse practitioners, nurse midwives and nurse anesthetists).	State law is lenient in directly reimbursing NPs in primary care and rural health centers. Direct physician contact is required in private settings.	A legislative bill allowing ARNPs to prescribe has been pre-filed for consideration in 1990.
Louisiana	R&Rs for NPs are promulgated by the BON.	There is only Medicaid reimbursement for CNMs.	No current legislative authority.
Maine	Specific regulations for NPs granted by BON; NPs are seeking revision this year with the goal of minimal regulation for advanced practice.	None for NPs but legislation was adopted to include reimbursement to master's-prepared, certified psych/mental health nurse specialists only.	Prescriptive authority is approved by BOM (NPs have their own DEA #). Limits in prescribing formulary by exclusion (i.e., narcotics).
Maryland	NPs are certified to practice through the BON; requirements include passing a nationally certified exam and written agreement with a responsible MD (the agreement is reviewed by an equally represented joint MD/NP committee).	Per legislation passed in 1986, all nurses are entitled to reimbursement for services as long as they are practicing within their legal scope of practice. Medical-assistance reimbursement remains pending; approval by the state legislature is anticipated shortly.	NPs prescribe medications as agreed upon in writing with physicians. The NP uses his or her own signature on the prescriptive pad; a list of NPs "certified to practice" is sent to pharmacists. There was a question several years ago whether the pharmacy regulations allowed "filling" of scripts written by NPs, but the attorney general's opinion was that NP scripts were as acceptable as any other provider's.
Massachusetts	Since 1975, nurses with additional education approved by the BON may perform certain additional acts under R&Rs approved by the BON and BOM. This includes NPs, CNMs, CRNAs and psychiatric nurse/mental health clinical specialists.	Psychiatric nurse/mental health clinical specialists and midwives are currently reimbursed due to state law. Bills are pending before the Legislature on reimbursement for NPs and CRNAs.	NPs, after registering with the Department of Public Health, may prescribe for patients in long-term-care facilities as well as for chronic-disease patients in their homes, if this would avoid their being institutionalized.

Key to Abbreviations Used in Table

BON - Board of Nursing
BOM - Board of Medicine
BONE - Board of Nurse Examiners
BOME - Board of Medical Examiners
R&Rs - Rules and Regulations
NPA - Nurse Practice Act
ANP - Advanced Nurse Practitioner
ARNP - Advanced Registered Nurse Practitioner
CNM - Certified Nurse Midwife
CRNA - Certified Registered Nurse Anesthetist
Practice - Respondents answered question, "What is the status of legal authority for advanced practice in your state?"
Reimbursement - Respondents answered question, "What is the status of reimbursement for nursing services in your state, including NPs?"
Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

10-8