Approved: 3-24-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 7, 1995 in Room 526-S of the Capitol.

All members were present except:
Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Others attending: See attached list

Discussion on SB 268 - Credentialing of health care personnel definitions

A balloon of **SB 268** proposed by KDHE was distributed to the Committee for review. (Attachment 1) The Chair noted that more and more requests are made for expansion of scope of practice today motivated by the various groups that provide health care wanting to be included in managed care contracts, and the elements of **SB 268** would be a neutral ground where information could be gathered and recommendations brought to the Committee in order that a decision could be made based on valid information.

A member felt that input was needed from all entities involved in the expansion of scope of practice and that such information be reviewed during the interim. Another member commented on material received from NCSL entitled "Regulating Health Professions" that told of states facing these same problems, and recommended a standing committee study this issue during the interim. (Attachment 2) Another member suggested that those entities involved should study the problem and come back with recommendations as a group and then the Committee could study such recommendations. It was noted by another member that there is no guarantee the bill would be studied during an interim if such committee is not approved by LCC.

Dr. Steve Potsic, KDHE, commented that the initial credentialing process can be long and involved, and that KDHE believes their role should be to protect the quality of the health status in Kansas. He noted that the cost could be more streamlined than the initial credentialing, and that experience suggests modification made in the process.

The Chair called attention to a 1992 bill provided by staff on credentialing of health care providers that was proposed by the Joint Committee on Health Care Decisions for the 1990s but never acted upon. It was noted the credentialing issue has been around for some time but nothing ever done to change the current process. There were three criteria when the credentialing process was established that had to be met, and in 1986 the statute was changed to specify nine criteria. It was noted that the Committee might want to look at establishing specific criteria for scopes of practice and not look at those nine criteria which deal more with initial credentialing rather than a change in the scope of practice.

Dr. Potsic noted additional regulations could be developed that would give more clarification to some of the standard criteria of scopes of practice, and that there should be no more than one individual of the applicant group on the technical advisory committee -- the remaining members are volunteer consumers. During discussion a suggestion was made that the membership of the advisory committee could be composed of members recommended by the regulatory boards. Gary Robbins, Kansas Optometric Association, suggested general guidelines would be more appropriate than statutory change.

The Chair noted there are specific questions that needed to be answered regarding scopes of practice in order to assure and improve assess to health care, maintain quality from the various providers, and hopefully control cost for the citizens of Kansas. The Chair announced a subcommittee would be formed to study the bill and recommendations brought back to the Committee for consideration. Members of that subcommittee are Senators Praeger, Walker and Hardenburger.

In answer to a member's question, Chip Wheelen, KMS, commented on an Attorney General's opinion that arose a few years ago regarding physicians who were statutorily authorized to diagnose and treat mental illnesses but were not authorized to diagnose and treat psychological disorders. (Attachment 3)

Excerpts from "Report to the 1993 Legislature" by the Joint Committee on Health Care Decisions for the 1990s on credentialing of health care providers was distributed to the Committee. (Attachment 4)

The meeting was adjourned at 10:45 a.m.
The next meeting is scheduled for March 8, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-7-95

NAME	REPRESENTING
Thomas E. Reed	KAOM
Bob Williams	Ks. Pharmacists Assoc
Tom Bell	KHA
Rebecca Rice	KPLA & KSOS
Joe Furjanic	KCA
Shelby Smith	KPMA
R.K. Driver	K.O.A.
Dean Unruh	KOA
Chuck Kissling	KOA
Gary Robbins	KSOpt Assn
Tom Bruno	Allied Assoc.
Rich Guthrie	Health Midwest
Tari Roberts	KSNA
Steve Kearney	KPTA
Steve Bos	KDHE

Session of 1995

SENATE BILL No. 268

By Committee on Public Health and Welfare

2-9

AN ACT concerning credentialing of health care personnel; amending K.S.A. 65-5001 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-5001 is hereby amended to read as follows: 65-5001. As used in this act unless the context requires otherwise, the following words and phrases shall have the meanings respectively ascribed to them herein:

(a) "Credentialing" or "credentialed" means *(1)* the formal recognition of professional or technical competence through the process of registration, licensure or other statutory regulation; *or (2) the formal change in the level of credentialing of a currently credentialed group whether certification, registration, licensure or other statutory regulation; or (3) the formal change in the customary or statutory scope of practice of a currently credentialed group*

(b) "Certification" means the process by which a nongovernmental agency or association or the federal government grants recognition to an individual who has met certain predetermined qualifications specified by the nongovernmental agency or association or the federal government.

(c) "Registration" means the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

(d) "Licensure" means a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful.

(e) "Health care personnel" means those persons whose principal functions, customarily performed for remuneration, are to render services, directly or indirectly, to individuals for the purpose of:

(1) Preventing physical, mental or emotional illness;

(2) detecting, diagnosing and treating illness;

(3) facilitating recovery from illness; or

(4) providing rehabilitative or continuing care following illness; and

who are qualified by training, education or experience to do so.

Credentialing Health Care Personnel

of health care personnel

Senate Public Health and Welfare
Date: 3-7-95
Attachment No. 1

(f) "Provider of health care" means an individual:

(1) Who is a direct provider of health care (including but not limited to a person licensed to practice medicine and surgery, licensed dentist, registered professional nurse, licensed practical nurse, licensed podiatrist, or physician's assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including medical care facilities, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

(2) who holds a fiduciary position with, or has a fiduciary interest in, any entity described in subsection (f)(3)(B) or subsection (f)(3)(D) other than an entity described in either such subsection which is also an entity described in section 501(c)(3) of the internal revenue code of 1954, as amended and supplemented, and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals or the production of drugs or articles described in subsection (f)(3)(C);

(3) who receives, either directly or through a spouse, more than 1/5 of such person's gross annual income from any one or combination of the following:

(A) Fees or other compensation for research into or instruction in the provision of health care;

(B) entities engaged in the provision of health care or in such research or instruction;

(C) producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care; or

(D) entities engaged in producing drugs or such other articles;

(4) who is a member of the immediate family of an individual described in subsection (f)(1), (f)(2) or (f)(3); or

(5) who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits. An individual shall not be considered a provider of health care solely because the individual is a member of the governing board of an entity described in subsection (f)(3)(B) or subsection (f)(3)(D).

(g) "Consumer of health care" means an individual who is not a provider of health care.

(h) "Secretary" means the secretary of health and environment.

Sec. 2. K.S.A. 65-5001 is hereby repealed.

See attached

Amend title and repealer as necessary

1-8

Sec. 2. K.S.A. 65-5002 is hereby amended to read as follows: 65-5002. (a) (1) If the application is for initial credentialing by the state, health care personnel seeking to be credentialed by the state shall submit a credentialing application to the secretary upon forms approved by the secretary. The application shall be accompanied by an application fee of $1,000. The secretary shall not accept a credentialing application unless such application is accompanied by the application fee and is signed by 100 or more Kansas resident proponents of credentialing the health care occupation or profession seeking to be credentialed.

(2) If the application is for a change of credentialing for a currently credentialed group of health care personnel, the application shall be submitted by a member or representative of the credentialed group upon forms approved by the secretary of health ~~care~~ personnel. The application shall be accompanied by an application fee of $1,000. In addition, the applicant shall agree to pay the full cost of the requested review as specified by the secretary of health and environment.

(b) All credentialing applications accepted by the secretary shall be referred to the technical committee for review and recommendation in accordance with the provisions of this act and rules and regulations adopted by the secretary. ~~The application fee established under this subsection (a) shall apply to every group of health care personnel which submits a credentialing application to the secretary on and after the effective date of~~

~~this--act--and--to-every-group-of-health-care-personnel-which-has not-filed-both--a--notice--of--intention--and--a--fully--answered application-before-the-effective-date-of-this-act.~~

~~(b)~~ (c) The secretary shall remit all moneys received from fees under this section to the state treasurer at least monthly. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury to the credit of the state general fund.

Sec. 3. K.S.A. 65-5003 is hereby amended to read as follows: 65-5003. (a) A technical committee shall be appointed by the secretary to examine and investigate each credentialing application referred by the secretary. Seven persons shall be appointed to each technical committee and such persons shall be appointed for a term of one year. Within 120 days after the expiration of such term, the secretary shall appoint a successor to fill such vacancy. The chairperson of the technical committee shall be designated by the secretary. Three members of the technical committee shall be health care personnel currently credentialed under the laws of this state. Four members of the technical committee shall be consumers of health care who are not also providers of health care. No member of the technical committee shall have a direct economic or personal interest in the credentialing ~~or~~, noncredentialing, level of credentialing or change in the statutory scope of practice of health care personnel whose application for credentialing will be reviewed by the technical committee. If a member of the technical committee

has a direct economic or personal interest in the credentialing ~~or~~, noncredentialing, level of credentialing or change in the statutory scope of practice of health care personnel whose application for credentialing will be reviewed by the technical committee or otherwise has a conflict of interest concerning the credentialing ~~or~~, noncredentialing, level of credentialing or change in the statutory scope of practice of health care personnel whose application for credentialing will be reviewed by the technical committee, the secretary shall replace such member on the technical committee by appointing a new member to the technical committee. The new member shall serve for the remainder of the term of the original member. A vacancy on the technical committee shall be filled by appointment within 120 days after such vacancy by the secretary for the remainder of the unexpired term of the vacant position.

(b) Each technical committee, as soon as possible after appointment of the members thereof, shall organize and review any credentialing application assigned to such committee by the secretary. The technical committee shall conduct fact-finding hearings and shall otherwise investigate the credentialing application.

(c) The technical committee shall attempt to obtain evidence and testimony from persons in support of the application and from persons opposed to the application, but evidence and testimony shall not be limited only to such persons. All interested persons shall have an opportunity to give evidence and testimony

subject to such reasonable conditions as may be established by the technical committee in the conduct of the hearing and subject to applicable rules and regulations established under this act. A notice of all meetings of the technical committee shall be published in the Kansas register at least 30 days prior to the day of the meeting. The notice shall state the time and place of the meeting.

(d) The technical committee shall make findings in an objective, unbiased manner based on the criteria established in K.S.A. 65-5006 and amendments thereto. Credentialing applicants shall have the burden of bringing forth evidence upon which findings may be made and shall have the burden of proving by clear and convincing evidence that the health care provider occupation or profession should be credentialed by the state, that a change should be made in the level of credentialing of a currently credentialed group of health care personnel or that a change should be made in the statutory scope of practice of a currently credentialed group of health care personnel. The evidence required to sustain this burden of proof shall be more than hypothetical examples or testimonials. The technical committee shall detail its findings in a report and shall file the report with the secretary. The technical committee shall complete hearings and shall file a report for any applicant group of health care personnel that has begun the process.

(e) If the technical committee determines after consideration of the evidence and testimony that all the criteria

established by law or by rules and regulations for credentialing have not been met and that credentialing is not appropriate, the technical committee shall recommend that an application for credentialing be denied. If the technical committee determines after consideration of the evidence and testimony that clear and convincing evidence has been presented that an occupational or professional group of health care personnel has met all the criteria established by law or by rules and regulations for the credentialing applied for and that the credentialing ~~by the state~~ applied for is appropriate, the technical committee shall recommend the application for credentialing be approved. If the technical committee recommends that the application for credentialing of health care personnel not currently credentialed be approved, there shall be included in the committee's report a recommendation of the level or levels of credentialing, and such recommendation shall be based upon a finding by the technical committee, stated in the report, that all criteria established by law or by rules and regulations for the recommended level or levels of credentialing have been met. ~~This recommendation~~ If the technical committee recommends that the application for a formal change in the level of credentialing of a currently credentialed group of health care personnel be approved, there shall be included in the committee's report a recommendation of the level or levels of credentialing, and such recommendation shall be based upon a finding by the technical committee, stated in the report, that all applicable criteria established by law or by

rules and regulations for the recommended level or levels of credentialing have been met. If the technical committee recommends that the application for a formal change in the statutory scope of practice of a currently credentialed group of health care personnel be approved, there shall be included in the committee's report a recommendation of the change in the statutory scope of practice, and such recommendation shall be based upon a finding by the technical committee, stated in the report, that all applicable criteria established by law or by rules and regulations for the recommended statutory scope of practice have been met. These recommendations shall be based on the criteria established in K.S.A. 65-5007 and amendments thereto.

Sec. 4. K.S.A. 65-5005 is hereby amended to read as follows: 65-5005. (a) Within 120 days after receiving the report and recommendations of the technical committee relating to a credentialing application, the secretary shall prepare a final report for the legislature. In preparing the final report, the secretary shall apply the criteria established by K.S.A. 65-5006 and 65-5007 and amendments to these sections as applicable to the credentialing application. The final report shall be submitted to the speaker of the house of representatives, to the president of the senate and to the chairpersons of the committees on public health and welfare for consideration by their respective committees. The secretary shall include the report of the technical committee in the final report prepared for submission

to the legislature. The secretary need not be bound by the recommendations of a technical committee.

(b) If the secretary determines after consideration of the report of the technical committee and the evidence and testimony presented to the technical committee that all criteria established by law or by rules and regulations for credentialing have not been met and that credentialing is not appropriate, the secretary shall recommend that no legislative action be taken on a credentialing application. If the secretary determines that clear and convincing evidence which was more than hypothetical examples or testimonials was presented to the technical committee that the applicant occupational or professional group of health care personnel should be credentialed ~~by-the-state~~ as requested in the application, that the applicant occupational or professional group of health care personnel has met all the criteria established by law or by rules and regulations for credentialing as requested in the application and that credentialing ~~by-the-state~~ as requested in the application is appropriate, the secretary shall recommend that the occupational or professional group of health care personnel be credentialed as requested in the application. If the secretary recommends that an occupational or professional group of health care personnel not currently credentialed be credentialed, the secretary shall recommend: (1) The level or levels of credentialing, and such recommendation shall be based upon a finding by the secretary, stated in the report, that all criteria established by law or by

rules and regulations concerning the recommended level or levels of credentialing have been met; (2) an agency to be responsible for the credentialing process and the level or levels of credentialing; and (3) such matters as the secretary deems appropriate for possible inclusion in legislation relating to the recommendation for credentialing. If the secretary recommends that the application for a formal change in the level of credentialing of a currently credentialed group of health care personnel be approved, there shall be included in the secretary's report a recommendation of the level or levels of credentialing, and such recommendation shall be based upon a finding by the secretary, stated in the report, that all applicable criteria established by law or by rules and regulations for the recommended level or levels of credentialing have been met. If the secretary recommends that the application for a formal change in the statutory scope of practice of a currently credentialed group of health care personnel be approved, there shall be included in the secretary's report a recommendation of the change in the statutory scope of practice, and such recommendation shall be based upon a finding by the secretary, stated in the report, that all applicable criteria established by law or by rules and regulations for the recommended statutory scope of practice have been met. The secretary shall also include in the report such matters as the secretary deems appropriate for possible inclusion in legislation relating to the recommendation on the credentialing application.

(c) No group of health care personnel shall be credentialed except by an act of the legislature. The final report of the secretary and the report and recommendations of the technical committee shall constitute recommendations to the legislature and shall not be binding upon the legislature. The legislature may dispose of such recommendations and reports as it deems appropriate.

Sec. 5. K.S.A. 65-5006 is hereby amended to read as follows: 65-5006. (a) The technical committee appointed pursuant to K.S.A. 65-5003 and amendments thereto and the secretary shall apply the following criteria to each credentialing application:

(1) The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public and the potential for such harm is recognizable and not remote;

(2) the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability;

(3) if the practice of the occupation or profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing health care services, such arrangement is not adequate to protect the public from persons performing noncredentialed functions and procedures;

(4) the public is not effectively protected from harm by certification of members of the occupation or profession or by

means other than credentialing;

(5) the effect of credentialing of the occupation or profession on the cost of health care to the public is minimal;

(6) the effect of credentialing of the occupation or profession on the availability of health care personnel providing services provided by such occupation or profession is minimal;

(7) the scope of practice of the occupation or profession is identifiable;

(8) the effect of credentialing of the occupation or profession on the scope of practice of other health care personnel, whether or not credentialed under state law, is minimal; and

(9) nationally recognized standards of education or training exist for the practice of the occupation or profession and are identifiable.

(b) Reports of the technical committee, and the secretary shall include specific findings on the criteria set forth in subsection (a). No report of the technical committee or the secretary shall recommend credentialing or a change in credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) and applicable to the credentialing application have been met.

Sec. 6. K.S.A. 65-5007 is hereby amended to read as follows: 65-5007. (a) All recommendations of the technical committee and the secretary which relate to the level or levels of

credentialing regulation of a particular group of health care personnel shall be consistent with the policy that the least regulatory means of assuring the protection of the public is preferred and shall be based on alternatives which include, from least regulatory to most regulatory, the following:

(1) Statutory regulation, other than registration or licensure, by the creation or extension of statutory causes of civil action, the creation or extension of criminal prohibitions or the creation or extension of injunctive remedies is the appropriate level when this level will adequately protect the public's health, safety or welfare.

(2) Registration is the appropriate level when statutory regulation under paragraph (a)(1) is not adequate to protect the public's health, safety or welfare and when registration will adequately protect the public health, safety or welfare by identifying practitioners who possess certain minimum occupational or professional skills so that members of the public may have a substantial basis for relying on the services of such practitioners.

(3) Licensure is the appropriate level when statutory regulation under paragraph (a)(1) and registration under paragraph (a)(2) is not adequate to protect the public's health, safety or welfare and when the occupational or professional groups of health care personnel to be licensed perform functions not ordinarily performed by persons in other occupations or professions.

(b) For credentialing applications for initial credentialing of a group of health care personnel or for a formal change in the level of credentialing of a currently credentialed group of health care personnel, reports of the technical committee and the secretary shall include specific findings on the criteria set forth in subsection (a). No report of the technical committee or the secretary shall recommend the level or levels of credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) for the recommended level or levels of credentialing have been met.

NCSL • LEGISBRIEF

March 1995 Vol. 3, No. 9

REGULATING HEALTH PROFESSIONS

By Brooke Wade

Who benefits most from licensing health professions—the public or the regulated profession? In the context of the changing health care climate, legislators are revisiting the dilemma: how to protect consumers without restricting the practice of qualified health workers.

Opponents of professional licensing question who's being protected when doctors regulate doctors. Supporters argue that licensing ensures quality, protecting the public from unqualified and unethical practitioners.

Ontario certifies medical procedures rather than professions.

The international community has tackled these questions and come up with new ways of regulating health professions. For example, Canada's Ontario Province has moved away from licensing broad scopes of practice and focused licensure on 13 actions that could cause harm to consumers. The new regulation protects consumers, while allowing qualified health professionals to practice beyond the historically rigid and territorial boundaries.

Possible Problems Created by Licensure Laws

- May restrict the supply of licensed practitioners in certain geographic areas.
- May result in increased costs to consumers.
- May create barriers that result in poor use of nonphysician health workers.
- May stifle innovations in the education and training of practitioners and in the organization and use of services.
- Entrance requirements may discriminate against minorities and the poor.

Positive Effects of Licensure Laws

- Keep unqualified or unethical practitioners from practicing.
- Monitor and discipline incompetent, fraudulent and negligent behavior.
- Ensure quality of service.
- Can lead to increased economic benefits (third-party reimbursement).
- Offer practitioners an opportunity for increased status.

Source: Pamela L. Brinegar and Kara L. Schmitt, *State Occupational and Professional Licensure, The Book of the States.* Lexington, Ky.: Council of State Governments, 1992: 567-568.

Legislators have to decide the appropriate level of control to protect the public.

Stateside, regulatory methods include licensure (legal right to deliver services), certification (title protection) and registration (provision of a roster to inform the public of the nature of a profession's services). State legislatures face the difficult decision of determining the appropriate level of control to protect the public from harm. The Council on Licensure, Enforcement and Regulation reports that 600 of the 1,100 professions and occupations regulated by states are regulated through licensure. Of those, fewer than 60 are regulated by more than half the states. Clearly, not every state measures potential for public harm by the same criteria.

State Actions

Past legislative activity regarding scopes of practice has included allowing nurse practitioners and certified nurse midwives to practice without direct physician supervision. Forty-four states have expanded prescriptive authority for nurse practitioners while 35 states allow physician assistants to prescribe medications. Nine states—ARKANSAS, IOWA, MICHIGAN, MONTANA, NEW HAMPSHIRE, NEW MEXICO, OREGON, RHODE ISLAND and UTAH—have granted nurse practitioners independent practice authority.

NATIONAL CONFERENCE OF STATE LEGISLATURES

Executive Director, William T. Pound

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Washington Office: 444 N. Capitol St., N.W., Suite 515

Senate Public Health & Welfare
Date: 3-7-95
Attachment No. 2

A MAINE health professions regulation project, modeled after the process Ontario used to develop its new regulations, has been under way since 1993 to get optimal use of limited health care workforce resources. To reach this goal, those involved in the project—health professionals, legislators, citizens, insurers and faculty of health professions' schools—have developed specific recommendations to be submitted to the Legislature this year.

Members of WASHINGTON's Health Care Workforce 2000 project plan to recommend changes in the state regulatory process and in health professions education. The recommendations will focus on a team approach to health care delivery, cultural sensitivity, protection of the public and increasing access through a primary care workforce.

COLORADO's Health Professions Panel plans to improve the licensure system for the best use of limited resources, ensuring that the state has the necessary information and data on health professionals to allow for meaningful workforce planning.

Some states are trying to improve coordination among the regulatory agencies.

Other state efforts aim at improving coordination among the numerous state regulatory bodies. TEXAS's Health Professions Council, established by the Legislature in 1993, must develop a plan to consolidate duplicate services of 29 separate health professions currently regulated by autonomous boards or the Department of Health. Services considered for consolidation are: mail room functions; personnel payroll and accounting; monitoring the status of applicants and members' licensure examinations; continuing education requirements; and initial disciplinary procedures.

In 1977, the VIRGINIA General Assembly created a Board of Health Professions to coordinate regulatory policy and to oversee the operation of the "umbrella" agency (Department of Health Professions) and its boards. The board eliminated more than half the regulations pertaining to professional practice, expanded the scope of practice of mid-level providers, and established policies related to ensuring continued competency. It is now overseeing the enforcement system that receives and adjudicates more than 3,000 complaints each year.

National health leaders recommend states increase the public's role in licensing.

National health workforce leaders and participants from COLORADO, MAINE, VIRGINIA and WASHINGTON recommend states consider the following when weighing new requests for licensure or re-examining existing regulatory laws: 1) Increase the public's role in the regulatory process; 2) Establish requirements to ensure the continued competence of the licensed professional; 3) Re-regulate health professional titles and potentially dangerous medical procedures; 4) Adopt outcome and evaluation studies to measure the effectiveness of regulatory law; 5) Collect relevant data and provide it to legislative committees and other groups developing workforce policy; 6) Recognize the consumer's need for access to relevant practitioner information including disciplinary action; and 7) Use nonadversarial and alternative dispute resolution systems to handle complaints against practitioners.

Selected References

Begun, James W. and Lippincott, Ronald C. *Strategic Adaptation in the Health Professions: Meeting the Challenges of Change.* San Francisco, Calif.: Jossey-Bass Publishers, 1993.

Shimberg, Benjamin and Roederer, Doug. *Questions A Legislator Should Ask*, Second Edition. Lexington, Ky.: The Council on Licensure, Enforcement and Regulation, 1994.

Contacts for More Information

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March 4, 1995

To: Senate Public Health and Welfare Committee

From: C. L. Wheelen, KMS Director of Public Affairs

Subject: Senate Bill 268; Credentialing of Health Care Personnel

During your discussion of SB268 on February 24, I was somewhat surprised to hear the comment that SB268 would not apply to the medical profession. I respectfully disagree with that statement.

A few years ago an Attorney General's opinion concluded that although physicians were statutorily authorized to diagnose and treat mental illnesses, they were not authorized to diagnose and treat psychological disorders. Although this seems preposterous, it was an interpretation of the letter of the law. Consequently, in my capacity as the appointed lobbyist for the Kansas Psychiatric Society, I requested an amendment that added the phrase "psychological disorders" to the scope of medicine and surgery under K.S.A. 65-2869. There was a lot of opposition, primarily because of misunderstanding. Some groups did not know about the AGs opinion and inferred meaning that was incorrect.

The important point is that occasionally the medical profession does need to request an amendment to the statutory scope of medicine and surgery. When that again becomes the situation, under SB268 we too would be compelled to apply to the Secretary of Health and Environment for credentialing review. I think it would be to our advantage to go through the process in order to make the hearings public and avoid the kind of misinformation and confusion that is sometimes characteristic of these scope of practice issues.

I would also comment based on my observation of the credentialing review process in the past. The Department of Health and Environment has cautiously avoided appointing members to the technical committee who might have had a biased perspective or professional interest in the outcome. Reviews have been conducted in a deliberate manner and oftentimes, the group seeking credentialing substantially revised its own position as a result of the factfinding exercise. It has always been a valuable, learning experience for everyone involved.

Thank you for considering these comments. We respectfully request that you recommend passage of SB268.

Senate Public Health & Welfare
Date: 3-7-95
Attachment No. 3

CREDENTIALING OF HEALTH CARE PROVIDERS

A paper by Klerman notes that nonfinancial barriers -- including legal restrictions, geographic isolation and provider shortages, provider practices and policies, and personal attributes and circumstances -- can prevent individuals from obtaining care.

BACKGROUND

One of the roles the state plays in the field of health care is that of provider regulation, *i.e.*, in Kansas, the licensing or registration of a group of providers who have completed a prescribed course of training and who meet other statutorily prescribed standards that allow members of the group to be licensed or registered by an agency of the state. Under the provisions of the Kansas Act on Credentialing, licensure grants the holder of a license an exclusive right to perform defined health care procedures and registration grants the holder the exclusive right to use a protected title that describes a specific aspect of health care. Registration does not prevent other qualified individuals from providing the same type of care.

Until the early 1970s, Kansas, as did most of the states, licensed physicians, chiropractors, dentists and dental hygienists, nurses, optometrists, and pharmacists. That is, the Kansas laws granted such persons the exclusive right to practice a health care profession regardless of the title conferred by law on the practitioner. Kansas also conferred on physical therapists the exclusive right to the use of the title "registered physical therapist." However in the several decades preceding the 1970s as new types of health care were developed and new procedures initiated, a large number of individuals became specialists in the provision of more limited aspects of health care or more specialized procedures. Although initially such persons were trained within the health care setting itself to perform, often under the direction of a credentialed provider, a limited scope of health care, more formalized training and education developed and state legislatures found themselves overwhelmed with health care groups petitioning for state regulation that would confer on them the exclusive right to practice some aspect of health care.

Kansas was no exception. At the same time the delivery of health care was becoming more fragmented in terms of who provided what services, there were two growing concerns about the health care system. One was the uneven geographic distribution of credentialed health care providers and the other the escalating cost of health care. Concern grew over the role that granting exclusive practice rights to even more groups of providers might play in both the ability to fully utilize the skills of such persons in settings in which there were provider shortages and in the escalation of the cost of health care. So great was the concern that the Secretary of the Department of Health, Education, and Welfare (the predecessor of the Department of Health and Human Services) asked the states to observe a two-year moratorium on the licensing of new health care provider groups.

The Kansas Legislature observed the moratorium and launched a series of interim studies which culminated in the passage of the Kansas Act on Credentialing which establishes a procedure under which groups seeking credentialing may apply to the Secretary of Health and Environment for review by a technical committee appointed by the Secretary of the need for

credentialing and the appropriate level of credentialing. The recommendations of the technical committee and the Secretary are transmitted to the Legislature as required by law. Although nothing in the credentialing laws preclude legislative action to license or register a health provider group that has not undergone the credentialing review authorized by law, no groups have been licensed without such a review since the Kansas Act on Credentialing was enacted.

COMMITTEE ACTIVITY

The Committee has reviewed two issues that concern the credentialing of health care personnel. The first is the issue of crosstraining of ancillary health personnel. Crosstraining has been receiving more attention in recent years as concern with the inefficiencies and inequities in health care delivery has increased. Crosstraining envisions changing training programs to emphasize skills that are related, but that in today's health care delivery system are delivered by separate personnel, each perhaps credentialed to provide a relatively narrow range of service. Crosstraining also allows the health care system in less heavily populated areas to make more efficient use of trained health care providers, especially in institutional settings that have difficulty in attracting and retaining ancillary health care providers and whose daily occupancy is such that staffing with individuals who can provide only one limited aspect of health care makes such services both expensive and inefficient.

A second issue that the Joint Committee reviewed reflects the recent attempts of several health care provider groups to broaden the scope of practice defined by statute, to increase the level of credentialing from registration to licensure, or to seek to become independent providers by deletion of the statutory requirements for referral or supervision. During the 1992 Session, the then Secretary of Health and Environment declined to respond to a request from a committee of the Legislature for a credentialing review of the desirability of expanding the scope of practice of a provider group that is currently subject to licensure. In the Secretary's response to the committee chair, it was indicated that the Kansas Act on Credentialing does not contain specific criteria for such a review although the Act does empower the Secretary to review the appropriateness of the continued credentialing and the level of credentialing of those provider groups that are licensed or registered under Kansas law. The Committee reviewed the credentialing statutes, heard conferees on credentialing issues, and requested the preparation of a bill draft, but does not have recommendations for amendment of the statutes to present to the 1993 Legislature.

RECOMMENDATIONS

The Joint Committee on Health Care Decisions for the 1990s believes that crosstraining of ancillary health care providers should be encouraged and that all those engaged in training such personnel at any level of education and training should examine their curriculum to pinpoint barriers and opportunities for crosstraining. Those agencies of the state that are assigned the responsibility for credentialing ancillary health care providers should also examine the requirements for registration they have established to determine if the education and training prescribed for registration create a bar to crosstraining of providers and utilization of persons who are so trained.

As a part of its review of crosstraining, the Committee also reviewed the Kansas laws on credentialing, particularly those acts that authorize the registration of specified ancillary health personnel. The members recommend that agencies of the state that are responsible for registering such persons review their regulations to be sure that such regulations reflect clearly the statutory intent to protect only the use of a specific title. Further, the Department of Health and Environment, the agency that licenses hospitals and nursing facilities, should review its regulations to be sure that such regulations do not imply that state registration is a requirement for meeting institutional licensing criteria.

The members believe that crosstraining should be further explored, particularly in those settings in which the skills of ancillary health care providers may not be efficiently and fully utilized.

The members of the Joint Committee support the current pre-credentialing review processes and believe that decisions either to grant initial credentialing to a health care provider group or to change or expand a practice definition should be subject to careful review since credentialing decisions can affect the mobility of health care personnel, the cost of health care, the efficient utilization of trained individuals, and the level of health services available in the state. While the Joint Committee has not presented amendments to the 1993 Legislature for consideration, the members note the recommendation of a conferee to expand the role of the technical committees convened pursuant to the Kansas Act on Credentialing to encompass review of any requests from health care provider groups to change a statutory scope of practice or to make other major changes in the statutory provisions relating to the practice of such individuals. (Note: See Committee minutes for July 15 and 16, 1992.) Additional input should be provided by the Secretary of Health and Environment as to the feasibility of such additional role for the technical committees on referral from a standing committee of the Legislature.