Approved: March 4, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on February 21, 1996 in Room 423-S of the State Capitol.

All members were present except: Representative Goodwin
Representative Kirk
Representative Merritt
Representative Yoh

Committee staff present: Emalene Correll, Legislative Research Department
Francie Marshall, Committee Secretary

Conferees appearing before the committee:
Dr. Kevin Koch, Emergency Physician, Shawnee Mission Medical Center
Tom Bell, Kansas Hospital Association
Harold Riehm, Kansas Association of Osteopathic Medicine
Tom Wilder, Kansas Insurance Department
Meg Henson, Kansas Medical Society
Cheryl Dillard, Health Net
Dr. Barter, Humana Health Care Plans
Gerard Grimaldi, Kaiser Permanente
R. E. "Tuck" Duncan, Medevac Medical Services

Others attending: See Guest List: Attachment 1.

Chairperson Mayans opened the hearing on **HB 3016.**

HB 3016 - Emergency medical care and prior insurer authorization

The following proponents presented testimony supporting **HB 3016**:
Dr. Kevin Koch, Emergency Physician, Shawnee Mission Medical Center, Merriam, KS (see Attachment 2),
Tom Bell, Kansas Hospital Association (see Attachment 3),
Harold Riehm, Kansas Association of Osteopathic Medicine (see Attachment 4),
Tom Wilder, Director of Government and Public Affairs, Kansas Insurance Department (see Attachment 5),
Meg Henson, Kansas Medical Society (see Attachment 6).

Questions were opened to the proponents from the committee.

Several questions were raised concerning the language of the bill, answering service of attending physicians, and the COBRA Act of 1986. On questions concerning the language of the bill, Ms. Correll questioned the interpretation of medical and traumatic conditions as requirements for a situation to be an emergency. Dr. Koch commented that it should be either a medical or traumatic condition, instead of both. The definitions of "hospitals", "physicians", and "providers" as stated in the bill were questioned. There was some discussion of **SB 477** which deals with HMOs. A brief overview was provided of how insurance companies handled emergency situations when they arise. Providing consumers with a better understanding of their policy so that they are aware of their coverage was discussed.

The hearing was open to the opponents to present their testimonies.

The following opponents presented testimony in opposition of **HB 3016:**
Cheryl Dillard, Public Affairs Director, HealthNet (see Attachment 7),
Dr. Bruce Barter, Humana Health Care Plans (see Attachment 8),
Gerald Grimaldi, Kaiser Permanente (see Attachment 9).

Mr. R.E. Tuck Duncan, Medevac Medical Services, provided testimony that is neutral of **HB 3016.** (see Attachment 10) He stated his concerns on prior approval for ambulance and about the definition in the bill

Questions were opened to the opponents and Mr. Duncan from the committee.

Questions were raised concerning ambulance service, health care providers, and policies. Comments were made that providing medical advice over the phone will save patients time and money. Concerns regarding health care providers and the problems of patients covered by HMO and other private carriers were discussed. On questions concerning policies, Representative Haley questioned the legality of a policy in regards to including one free visit to the emergency room and increase the premiums for any following emergency room visits. The reasoning behind this would lessen the frequency of some patients who visit the emergency room for non-emergency situations.

The hearing was closed on **HB 3016.**

HB 2771 - Change in scope of practice or level of credentialing

Chairperson Mayans reminded the committee that at the hearing on this bill, there were concerns how to address issues dealing with scope of practice. After the hearing, many concerns were raised by providers. The providers met and drafted a compromise which became substitute for **HB 2771** (see Attachment 11). Terri Roberts, Kansas Nurses' Association, reported that all parties concerned agreed on the seven criteria questions in the draft. She stated the issues dealing with the change of credentialing level and what the mechanism should be, were unresolved. Ms. Correll pointed out to the committee that the level of credentialing is mentioned in the seventh question of the draft, and asked if it was intentionally left in. Ms. Roberts replied, yes.

Following more discussion of the draft substitute for **HB 2771**, on motion of Representative Morrison, seconded by Representative Haley, the committee amended **HB 2771** by adopting **substitute 2771**.

On motion of Representative Morrison, seconded by Representative Haley, the committee voted by voice vote to pass **substitute 2771** favorably. Representative Morrison will carry the legislation.

The meeting was adjourned at 2:55 p.m.

The next meeting is scheduled for February 22, 1996.

House Health & Human Services COMMITTEE GUEST LIST

DATE February 21, 1996

NAME	REPRESENTING
Tom Wilder	Kansas Insurance Dept
Rick Guthrie	Health Midwest
Joe Turgeon	KCA
MaryAnn Gabbel	BSRB
Kevin York	American College Emergency Physicians, KS Chapter
Kathy Peterson	Prudential
Meg Henson	KS Medical Society
John Federico	Pete McGill + Assoc
Bruce Barton, MD	Humana Health Care Plans
Harry Spring	Humana
Aaron Reid	KSNA
Rick Mears	Ks. Health Institute
Philip Hurley	Patrick J. Hurley & Co.
Teresa Silvernail	HIAA
Craig Kieffer	KAOM
Bob Weinfurter	SRS Medical
Gary Robbins	Ks Optometric Assn
Cheryl Dillard	HealthNet
Bill Grosz	SMMC
Karrie Ann Brown	KHA
Melissa Wangemann	Hein Event & Wear
Steve Kearney	CIGNA
Carole Yates	CIGNA
Michelle Peterson	Peterson Public Affairs Group

H & HS Comm.
2-21-96
Attn #1

HOUSE BILL 3016

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, KANSAS CHAPTER
KEVIN KOCH, M. D., F.A.C.E.P., PRESIDENT
EMERGENCY PHYSICIAN, SHAWNEE MISSION MEDICAL CENTER, MERRIAM, KS

I come before you today as a practicing Emergency Physician to request passage of this bill to create fair treatment for patients and to help restore the balance between insurance companies and consumers. This request is motivated by an increasing problem that is occurring in Emergency Departments throughout the country and in Kansas. Patients will present for treatment of conditions that are painful or unknown, receive proper evaluation and later their insurance carrier in an arbitrary, retrospective fashion will decide the condition was not a " true emergency " and deny to cover or reimburse the patient based on what the final diagnosis was.

This is unfair to consumers and needs to be corrected. This bill will do that. Initial symptoms are all that patients have to go on when they become ill. How are they to know a sudden unusual headache is a migraine or a ruptured aneurysm in their brain? This practice of insurance companies and managed care plans denying coverage based on final diagnosis is forcing patients to diagnose themselves under emergency circumstances for fear that their medical bills may not be covered. What's next? If a woman has a biopsy for a breast mass and it turns out not to be cancerous will she be responsible for the bill? This issue is a growing problem.

Emergency Physicians are the only physician group mandated by the Federal Government (COBRA '86) to provide evaluation and diagnostic services to patients regardless of their ability to pay or their insurance status. HMO's are well aware of this and take advantage of this law to the detriment of their patients. They know their patients will receive emergency care, however the patients don't realize it may not be covered due to vague language in plans' benefit summaries. This bill will correct this in behalf of patients throughout Kansas by defining what an emergency is due to symptoms and not final diagnosis.

Examples.

For the last five years I have been Chairman of the Emergency Department at Shawnee Mission Medical Center and have witnessed an ever increasing number of patient appeals to me to assist them in getting their insurance carriers to honor their bona fide emergency visits. I now estimate I spend 2 hours per week writing appeals to carriers. If there was a uniform definition of an emergency this issue would be resolved to the benefit of all health care consumers in Kansas.

Lastly, many health care attorneys I have spoken with are of the opinion this issue may become an increasing problem in regards to litigation and passage of this bill will assist in relieving the burden that the Kansas courts are already struggling under by defining a medical emergency.

Thank you for your consideration of my testimony.

Sincerely,

Ken Koch, M.D.

Kevin Koch, M.D., F.A.C.E.P.

H+HS Comm
2-21-96
Attm #2

EXAMPLES:

By the definition of an " emergency " used by some insurance carriers and HMOs, the following clinical conditions may not be covered if a patient is treated in an Emergency Department in a Kansas hospital:

1. A young woman with severe pelvic pain, who fears she may have a miscarriage, bleeding ovarian cyst, tubal pregnancy or infection.

2. A child who hit his head on a playground and is now vomiting and dizzy.

3. A patient with 12 hours of vomiting, diarrhea and abdominal cramps, not getting better despite the phone advice of the HMO.

4. An 84 year old woman who fell and cannot use her arm.

5. A middle-aged man who develops chest pain while shoveling snow, trouble breathing, whose father died of a heart attack.

In all these cases, whether authorized or not, the HMO, in some office somewhere, will decide retrospectively whether the FINAL DIAGNOSIS was an emergency or not. If:

1. A diagnosis of a urinary tract infection;
2. A diagnosis of a scalp contusion;
3. A diagnosis of viral gastroenteritis or food poisoning;
4. A diagnosis of a shoulder sprain;
5. A diagnosis of chest wall pain or esophageal reflux

is made, the visit to the Emergency Department may not be covered by the HMO plan.

The New York Times

H.M.O.'S REFUSING EMERGENCY CLAIMS, HOSPITALS ASSERT

2 MISSIONS IN CONFLICT

'Managed Care' Groups Insist They Must Limit Costs — Doctors Are Frustrated

By ROBERT PEAR

WASHINGTON, July 8 — As enrollment in health maintenance organizations soars, hospitals across the country report that H.M.O.'s are increasingly denying claims for care provided in hospital emergency rooms.

Such denials create obstacles to emergency care for H.M.O. patients and can leave them responsible for thousands of dollars in medical bills. The denials also frustrate emergency room doctors, who say the H.M.O. practices discourage patients from seeking urgently needed care. But for their part, H.M.O.'s say their costs would run out of control if they allowed patients unlimited access to hospital emergency rooms.

How H.M.O.'s handle medical emergencies is an issue of immense importance, given recent trends. Enrollment in H.M.O.'s doubled in the last eight years, to 51 million in 1994, partly because employers encouraged their use as a way to help control costs.

In addition, Republicans and many Democrats in Congress say they want to increase the use of H.M.O.'s because they believe that such prepaid health plans will slow the growth of Medicare and Medicaid, the programs for the elderly and the poor, which serve 73 million people at a Federal cost of $267 billion this year.

Under Federal law, a hospital must provide "an appropriate medical screening examination" to any patient who requests care in its emergency room. The hospital must also provide any treatment needed to stabilize the patient's condition.

Dr. Toni A. Mitchell, director of emergency care at Tampa General Hospital in Florida, said: "I am obligated to provide the care, but the H.M.O. is not obligated to pay for it. This is a new type of cost-shifting, a way for H.M.O.'s to shift costs to patients, physicians and hospitals."

Most H.M.O.'s promise to cover emergency medical services, but there is no standard definition of the term. H.M.O.'s can define it narrowly and typically reserve the right to deny payment if they conclude, in retrospect, that the conditions treated were not emergencies. Hospitals say H.M.O.'s often refuse to pay for their members in such cases, even if H.M.O. doctors sent the patients to the hospital emergency rooms. Hospitals then often seek payment from the patient.

Dr. Stephan G. Lynn, director of emergency medicine at St. Luke's-Roosevelt Hospital Center in Manhattan, said: "We are getting more and more refusals by H.M.O.'s to pay for care in the emergency room. The problem is increasing as managed care becomes a more important source of reimbursement. Managed care is relatively new in New York City, but it's growing rapidly."

H.M.O.'s emphasize regular preventive care, supervised by a doctor who coordinates all the medical services that a patient may need. The organizations try to reduce costs by redirecting patients from hospitals to less expensive sites like clinics and doctors' offices.

The disputes over specific cases reflect a larger clash of missions and cultures. An H.M.O. is the ultimate form of "managed care," but emergencies are, by their very nature, unexpected and therefore difficult to manage. Doctors in H.M.O.'s carefully weigh the need for expensive tests or treatments, but in an emergency room, doctors tend to do whatever they can to meet the patient's immediate needs.

Continued on Page 22, Column 3

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H .O.'s Refusing Emergency-Care Claims, Hospita. Sa

Continued From Page 1

Each H.M.O. seems to have its own way of handling emergencies. Large plans like Kaiser Permanente provide a full range of emergency services around the clock at their own clinics and hospitals. Some H.M.O.'s have nurses to advise patients over the telephone. Some H.M.O. doctors take phone calls from patients at night. Some leave messages on phone answering machines, telling patients to go to hospital emergency rooms if they cannot wait for the doctors' offices to reopen.

At the United Healthcare Corporation, which runs 21 H.M.O.'s serving 3.9 million people, "It's up to the physician to decide how to provide 24-hour coverage," said Dr. Lee N. Newcomer, chief medical officer of the Minneapolis-based company.

George C. Halvorson, chairman of the Group Health Association of America, a trade group for H.M.O.'s, said he was not aware of any problems with emergency care. "This is totally alien to me," said Mr. Halvorson, who is also president of HealthPartners, an H.M.O. in Minneapolis. Donald B. White, a spokesman for the association, said, "We just don't have data on emergency services and how they're handled by different H.M.O.'s."

About 3.4 million of the nation's 37 million Medicare beneficiaries are in H.M.O.'s. Dr. Rodney C. Armstead, director of managed care at the Department of Health and Human Services, said the Government had received many complaints about access to emergency services in such plans. He recently sent letters to the 164 H.M.O.'s with Medicare contracts, reminding them of their obligation to provide emergency care.

Alan G. Raymond, vice president of the Harvard Community Health Plan, based in Brookline, Mass., said, "Employers are putting pressure on H.M.O.'s to reduce inappropriate use of emergency services because such care is costly and episodic and does not fit well with the coordinated care that H.M.O.'s try to provide."

Dr. Charlotte S. Yeh, chief of emergency medicine at the New England Medical Center, a teaching hospital in Boston, said: "H.M.O.'s

What happens when 'managed care' meets unplanned emergencies.

are excellent at preventive care, regular routine care. But they have not been able to cope with the very unpredictable, unscheduled nature of emergency care. They often insist that their members get approval before going to a hospital emergency department. Getting prior authorization may delay care.

"In some ways, it's less frustrating for us to take care of homeless people than H.M.O. members. At least, we can do what we think is right for them, as opposed to trying to convince an H.M.O. over the phone of what's the right thing to do."

Dr. Gary P. Young, chairman of the emergency department at Highland Hospital in Oakland, Calif., said H.M.O.'s often directed emergency room doctors to release patients or transfer them to other hospitals before it was safe to do so. "This is happening every day," he said.

The PruCare H.M.O. in the Dallas-Fort Worth area, run by the Prudential Insurance Company of America, promises "rock solid health coverage," but the fine print of its members' handbook says, "Failure to contact the primary care physician prior to emergency treatment may result in a denial of payment."

Typically, in an H.M.O., a family doctor or an internist managing a patient's care serves as "gatekeeper," authorizing the use of specialists like cardiologists and orthopedic surgeons. The H.M.O.'s send large numbers of patients to selected doctors and hospitals; in return, they receive discounts on fees. But emergencies are not limited to times and places convenient to an H.M.O.'s list of doctors and hospitals.

H.M.O.'s say they charge lower premiums than traditional insurance companies because they are more efficient. But emergency room doctors say that many H.M.O.'s skimp on specialty care and rely on hospital emergency rooms to provide such services, especially at night and on weekends.

Dr. David S. Davis, who works in the emergency department at North Arundel Hospital in Glen Burnie, Md., said: "H.M.O.'s don't have to sign up enough doctors as long as they have the emergency room as a safety net. The emergency room is a backup for the H.M.O. in all it operations." Under Maryland law, he noted, an H.M.O. must have a system to provide members with access to doctors at all hours, but it can meet this obligation by sending patients to hospital emergency rooms.

To illustrate the problem, doctors offer this example: A 57-year-old man wakes up in the middle of the night with chest pains. A hospital affiliated with his H.M.O. is 50 minutes away, so he goes instead to a hospital just 10 blocks from his home. An emergency room doctor orders several common but expensive tests to determine if a heart attack has occurred.

The essence of the emergency physician's art is the ability to identify the cause of such symptoms in a patient whom the doctor has never seen. The cause could be a heart attack. But it could also be indigestion, heartburn, stomach ulcers, anxiety, a panic attack, a pulled muscle or any of a number of other conditions.

If the diagnostic examination and tests had not been performed, the hospital and the emergency room doctors could have been cited for violating Federal law.

But in such situations, H.M.O.'s often refuse to pay the hospital, on the ground that the hospital had no contract with the H.M.O., the chest pain did not threaten the patient's life or the patient did not get authorization to use a hospital outside the H.M.O. network.

Representative Benjamin L. Cardin, Democrat of Maryland, said he would soon introduce a bill to help solve these problems. The bill would require H.M.O.'s to pay for emergency medical services and would establish a uniform definition of emergency based on the judgment of "a prudent lay person." The bill would prohibit H.M.O.'s from requiring prior authorization for emergency services. A health plan could be fined $10,000 for each violation and $1 million for a pattern of repeated violations.

The American College of Emergency Physicians, which represents more than 15,000 doctors, has been urging Congress to adopt such changes and supports the legislation.

When H.M.O.'s deny claims filed on behalf of Medicare beneficiaries, the patients have a right to appeal. The appeals are heard by a private consulting concern, the Network Design Group of Pittsford, N.Y., which acts as agent for the Government. The appeals total 300 to 400 a month, and David A. Richardson, president of the company, said that a surprisingly large proportion — about half of all Medicare appeals — involved disagreements over emergencies or other urgent medical problems.

2-4

Did You Know...

Managed Care Plans Could Be Harmful For Patients With Medical Emergencies?

As managed care health plans proliferate in the United States, there is a growing problem which requires the attention of the Congress. Emergency physicians believe strongly that an effort to define emergency medical services must be made in order to protect the health and financial interests of managed care plan enrollees.

Background

Managed care plans are increasingly engaging in retrospective denial of payment for services based on discharge diagnosis rather than on the symptoms present when the patient came to the emergency department. This practice presents a myriad of problems for those subscribers, including placing the responsibility on the patient to determine whether their condition truly is an emergency.

Emergency physicians are not opposed to managed care, and believe health care costs should be constrained where appropriate. However, the rapid growth of managed care systems, combined with the lack of regulatory or legislative control over their operations pose particularly ominous health and financial implications to the citizens of our country.

Here Are The Facts:

- Managed care plan purchasers and enrollees are assured that emergency services are covered. However, in many of the plans' benefit summaries, the language covering emergency services is vague and requires the enrollee to judge whether seeking emergency care is appropriate. Patients are cautioned that if their condition is determined retrospectively not to be an emergency, they may be financially liable.

- Requiring a layperson to determine whether their condition is an emergency is unrealistic and dangerous. Even emergency physicians with many years of experience must first perform an examination and evaluate test results to make a diagnosis before judging some conditions as non-emergent.

- Managed care plans erect significant barriers between their enrollees and the emergency care system. Inserting a "gatekeeper" between the patient and emergency department can have a serious impact on patient outcomes, especially when time is of the essence.

- Federal law requires that every patient presenting to an emergency department must receive an adequate screening examination and be stabilized if necessary. There is no corresponding requirement that these services must be reimbursed by the managed care plan. There is an increasing rate of denial by managed care plans. In 1992 a study conducted for the Health Care Financing Administration determined that 60% of the claims denied by Medicare HMOs were for emergency medical services. The authors concluded that these cases were dispute prone because patients were put in the untenable position of having to make quasi-clinical judgments about their condition, only to be second-guessed by the HMO after the emergent event.

Assessed Your New Risks?

Patricia McAnany

Managed Care

This may be a true conundrum for hospital risk managers and attorneys. Basically, the final rule indicates that "managed health care plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will or will not pay for. However, regardless of whether a hospital is to be reimbursed for the treatment, it is obligated to provide the services specified in the statute." (Reference pg. 32116.)

There are further comments that a patient's obligation to pay for services is beyond the scope of the regulations, and consequently, will not be addressed. Basically, we are obligated to provide care that is needed whether or not we have a promise of payment either by the individual or a managed care provider. From a professional liability viewpoint, we have always been obligated to meet the standard of care regardless of the ability to pay. It is even more pertinent now to avoid "no win" situations with managed care providers and complete a formal, thorough medical screening examination and treatment. I visited with an attorney who feels that there will be extensive litigation against managed care providers in this area. The writer is also aware of litigation that indicates a patient/physician relationship has already been established when a managed care participant is treated in a hospital emergency department and the plan's doctor on call is consulted about treatment or admission. (Hand v. Tavesa, 864 S.W.2d 678; test. App. San Antonio 199.) All in all, payment issues must be excluded in the total diagnostic workup of the patient.

NEVER, EVER allow payment discussions to direct the care.

Documentation

The final rule includes some significant additions. First of all, the hospital must maintain its on-call duty roster, medical records, and ED/ER log of individuals seeking care for five years. Next, the signage indicating that emergency care is available must be visible from 20 feet and posted in other entrance and patient-gathering areas of the hospital besides the emergency department. There is additional conversation in the rules that indicates the potential for sending the patient's old chart with the transfer if it is available; "informed" consents/refusals of transfer require greater physician documentation.

Reporting Responsibilities

The newest addition to COBRA is that hospitals are required to report a suspected "dump" or other inappropriate transfer within a specified time period (72 hours). This is seen as a potential issue and may strain relationships among many hospitals. Let me give you an example that happened in another state two weeks ago:

> Hospital A received a visit by an OB patient in its emergency department. The patient stated that her "water" had broken and that she was having mild contractions. She also volunteered that she was a clinic patient seen in Hospital B's clinic. She was advised to get back in her private vehicle and go over to Hospital B for treatment because "that's where her records were". What would you do as the risk manager at Hospital B? He was notified by telephone and incident report that this occurred. He contacted the emergency room director and the risk manager at Hospital A and asked them for a review. He specified a 72-hour follow-up, and Hospital A called back to indicate that they would "turn themselves in".

This writer does not expect that all cases will be as clear-cut or as easily handled. However, this is an area that must be strongly reviewed to protect your institution from potential fines should a later COBRA allegation be discovered and investigated. And, you must consider how to delicately process an event with another institution.

Psychiatric/Substance Abuse Patients

The newest regulations clearly expanded the definition of "emergency medical condition" to include "psychiatric disturbances and symptoms of substance abuse". It also indicated that acute medical care for alcohol detoxification could be considered well within the capabilities of the receiving hospital and should not immediately be considered as a reason for transfer to a mental health or chemical dependence unit.

A potent risk management tool in relation to any patients with these diagnoses is a concerted effort with local "gatekeepers", community mental health providers, and other on-call specialists in these fields. As indicated in my opening paragraph, the governing board should also clearly outline when it is appropriate for non-physicians to provide the emergency medical screening exam.

Professional Liability Coverage

Another area that should be actively explored is whether there is coverage under either the hospitals' or physicians' policies for COBRA violations. In many situations,this may be excluded since it is not strictly professional liability, but a violation of federal law. Some insurance carriers explicitly exclude coverage. While the case law shows mixed components of both professional liability claims and civil actions under COBRA, this is where legal counsel and senior management should review potential exposure.

continued page 12

2-6

Request For A Bill

" An Act To Define Emergency Medical Care"

Section 1. Policy and purpose. Because of the need for rapid assessment and care, in order to protect the life and health of the people of Kansas, during a medical emergency, it is hereby found and declared necessary:

(1) to establish a definition for Emergency Medical Care;

(2) to insure that emergency medical care is provided in a timely manner by licensed and qualified personnel at a hospital's emergency department;

(3) to insure that emergency medical care is not delayed or denied based on:

(A) a person's ability to pay for expenses incurred during a medical emergency;

(B) prospective authorization of treatment by an insurance company, health maintenance organization, hospital medical service corporation, health benefit plan, or any other insurer.

Section 2. Definitions.

(1) Emergency medical care refers to health care services provided in a hospital emergency facility to evaluate and treat medical and traumatic conditions of a recent onset and severity, including , but not limited to , severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in : 1) placing the patient's health in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

(2) Prospective authorization means contacting any insurer , health maintenance organization, hospital medical services corporation, or health benefit plan who is not physically present in the hospital's emergency department, at the time the patient presents for emergency medical care,

as defined above, for approval or authorization to evaluate and treat the patient.

(3) Emergency medical providers refers to hospitals licensed by the Kansas Board of Healing Arts, hospital based services, and physicians licensed by the Kansas State Medical Board who provide emergency medical care.

Section 3. Procedures.

(1) Once a person qualifying for emergency medical care, based on the definition in Section 2 (1) above, presents to an emergency department, that person shall be evaluated by medical personnel. This evaluation may include diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic interpretations by a radiologist or emergency physician.

(2) Prior authorization is not required for emergency care including a medical screening exam, and stabilizing treatment as defined in Section 1867 of the Social Security Act.

(3) Appropriate intervention may be initiated by medical personnel to stabilize any condition presenting under this act prior to receiving authorization for such treatment by an insurer, health maintenance organization, hospital medical service corporation, or health benefit plan.

KA[illegible]HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

TO: House Health and Human Services Committee

FROM: Kansas Hospital Association

RE: HB 3016

DATE: February 21, 1996

The Kansas Hospital Association appreciates the opportunity to comment in support of House Bill 3016. This proposal prohibits health insurance plans from requiring prior authorization for emergency treatment rendered by health care providers.

With respect to hospitals, both federal and state law mandate that when a person presents at the emergency room they have the right to treatment regardless of their ability to pay. (see attached) In fact, the federal law even prohibits any inquiry about the person's payment capabilities prior to the initiation of such treatment.

We are supportive of the general duties created by these laws. It seems unfair to us that while the hospital is under a clear duty to treat the patient who shows up at the emergency room without asking questions, the patient's health insurance plan should be given the luxury of requiring prior authorization before payment.

Thank you for your consideration of our comments.

TLB / pc
Attachment

H + HS Comm
2-21-96
attm #3

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

EMERGENCY SERVICE REQUIREMENTS

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either —

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(U.S. Code)

28-34-16a. Emergency services. (a) Emergency services plans. Each hospital shall maintain a comprehensive, written emergency services plan based on community need and on the capability of the hospital. This plan shall include procedures whereby an ill or injured person can be addressed and either treated, referred to an appropriate facility or discharged. Regardless of the scope of its services, each hospital shall provide and maintain equipment necessary to institute essential life-saving measures for inpatients and, when referral is indicated, shall arrange for necessary transportation.

(b) Organized emergency services. In hospitals with organized emergency services, the following shall apply.

(1) Emergency services shall be available 24 hours a day, and medical staff coverage shall be adequate so that the patient will be seen within a period of time which is reasonable relative to the severity of the patient's illness or injury.

(2) No patient shall be transferred until the patient has been stabilized. A written statement of the patient's immediate medical problem shall accompany the patient when transferred. Every patient seeking medical care from the emergency services who is not in need of immediate medical care or for whom services cannot be provided by the hospital shall be given information about obtaining medical care.

(3) The emergency service, regardless of its scope, shall be organized and integrated with other departments of the hospital.

(4) The service shall be directed by a physician. The governing body shall adopt a written statement defining the qualifications, duties, and authority of the director. In the absence of a single physician, the direction of emergency medical services may be provided through a multidisciplinary medical staff committee, including at least one physician. The chairperson of this committee shall serve as director.

(5) The emergency nursing service shall be directed and supervised by a registered nurse with training in cardiopulmonary resuscitation. At least one registered nurse with this training shall be available at all times.

(6) The emergency service area shall be located near an outside entrance to the hospital and shall be easily accessible from within the hospital. Suction and oxygen equipment and cardiopulmonary resuscitation units shall be available and ready for use. This equipment shall include equipment used for tracheal intubation, tracheotomy, ventilating bronchoscopy, intra-pleural decompression and intravenous fluid administration. Standard drugs, parental fluids, plasma substitutes and surgical supplies shall be on hand for immediate use in treating life-threatening conditions.

(7) Written policies and procedures which delineate the proper administrative and medical procedures and methods to be followed in providing emergency care shall be established. A medical record shall be kept for each patient receiving emergency services and it shall be made a part of any other patient medical record maintained in accordance with K.A.R. 28-34-9a and amendments thereto.

(Kansas Administrative Regulations)

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

February 21, 1996

To: Chairman Mayans and Members, House Committee on Health and Human Services

From: Harold Riehm, Executive Director, KAOM

Subject: Testimony in Support of H.B. 3016

On several occasions before this Committee I have referred to the critical elements of health care that are of concern to government - cost, quality and access. H.B. 3016 addresses one of several inevitable conflicts that occur, and will so with increasing frequency, as cost containment continues to be an important objective. At question is quality or timliness of care received.

In this case, cost considerations, i.e., requirements for prior authorization or pre-certification for emergency room care (and reimbursement), as imposed by some insurance carriers and/or managed care institutions, is in conflict with the immediacy of care at times necessitated in emergency health situations.

While HOMs and other managed care companies should be encouraged to continue pursuit of cost containment, so also must the State be concerned with making sure that pursuit does not require conformity to practices that inhibit or slow the treatment under emergency conditions.

While language like ". . . prudent lay person, possessing an average knowledge of medicine and health . . ." may sound like a subjective criterium, we suggest it is reasonable. Much of the concern about overuse of emergency room facilities by patients for what is described as less that emergency conditions, is by persons without any insurance at all. We must be prepared, we think, to assume that persons have some knowledge about the health of their own body, and permit them, within reason, to seek care when they perceive it necessary.

There is a parallel, we think, between this issue (H.B. 3016) and regular physical check-ups or exams. When such exams are covered by insurance, frequency of use increases. Similarly, when ER care retains patient initiative, its frequency may increase, but so also might the alleviation of life threatening emergency health conditions.

Osteopathic physicians are particularly sensitive to "rules" and requirements of insurance carriers that limit access either to osteopathic physicians or to osteopathic manipulative treatment. We will be addressing those issues in subsequent years.

I will be pelase to respond to questions.

H+H S Comm
2-21-96
Attm #4

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Health and Human
Services Committee

From: Tom Wilder, Director of
Government and Public Affairs

Re: H.B. 3016 (Emergency Medical Services)

Date: February 21, 1996

The Kansas Department of Insurance appears today in support of the concept behind House Bill 3016 which is to provide payment under health insurance plans for emergency medical care. The Department receives a number of consumer complaints each year from insurance policyholders who are denied payment for treatment at hospital emergency rooms because a prospective review by the insurance company or health maintenance organization determined that such treatment was not medically necessary.

The Insurance Department agrees that insurers should not pay for treatment at an emergency room in those cases where the insured should have sought treatment from their family physician or other medical provider because the medical problem does not warrant emergency medical services. However, there are instances where the insured has a legitimate concern that they have an emergency medical situation which after an examination is determined to be non-life threatening. In those cases, the insurance company or managed care organization should not be allowed to deny payment because the insured made a wrong judgment call about the seriousness of their medical condition.

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Under those situations where the insured legitimately believes there is a medical emergency, that judgment should be accepted by the insurer.

The provisions in H.B. 3016 are taken, in part, from regulations proposed by Texas Governor George Bush which are under consideration by the Texas Insurance Department. I have attached the language from the proposed Texas rules which may be more appropriate. In addition, the bill should be amended to provide that appropriate pre-authorization by the insurance company or health maintenance organization will be sufficient if such authorization is timely provided. I would also note that H.B. 3016 refers to medical providers and hospitals which are licensed by the State of Kansas. These provisions do not help insureds who seek emergency medical treatment out of state. I suggest that the definition of "hospital," "emergency medical providers" and "provider" be changed to cover those instances where the emergency services are provided outside of Kansas.

The Kansas Insurance Department requests your support for the concepts set forth in H.B. 3016.

Texas Insurance Department
Proposed Regulations
Part 1, Section 3
Section 3.3704 (4)

An insurer may not deny reimbursement for emergency care services, including reimbursement for any initial medical screening examination to determine whether an emergency medical condition exists or other evaluation required by state or federal law to be provided in the emergency department of a hospital. An insurer may not deny reimbursement for medically necessary emergency care including the treatment and stabilization of an emergency medical condition. If an insured receives care under emergency conditions or services originating in a hospital emergency department following treatment and stabilization and can not reasonably reach a preferred provider, that care must be reimbursed at the preferred provider level of benefits until the insured can reasonably be expected to safely transfer to a preferred provider.

KANSAS MEDICAL SOCIETY
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WATS 800-332-0156 FAX 913-235-5114

February 21, 1996

To: House Health and Human Services Committee

From: Meg Henson
Director of Government Affairs

Subj.: HB 3016 - Emergency Medical Care

The Kansas Medical Society appreciates the opportunity to appear before you today in support of the principle contained in HB 3016. This legislation establishes a definition of "emergency medical care" based on the prudent layperson standard and eliminates the requirement that patients receive prior authorization from an insurer before providing emergency medical care.

The Kansas Medical Society supports the concept of requiring physicians or other health care providers to examine, evaluate and treat individuals seeking treatment in a hospital emergency room. This is currently required by federal law. The key issue in this legislation addresses a problem that physicians who work in emergency departments face. Although physicians are required by federal law to evaluate and treat any person who walks through the doors of an emergency room seeking care, many insurance companies review each case after-the-fact, often denying reimbursement for the provision of the care that physicians were required by law to provide.

We are grateful for the opportunity to offer these comments and would be happy to respond to any questions you might have.

H + HS Comm
2-21-96
Attm #6

HEALTHNET

To: Kansas House Health and Human Services Committee
From: Cheryl Dillard, Public Affairs Director, HealthNet
Date: February 21, 1996
Re: House Bill 3016; Emergency Medical Care

Mr. Chairman, members of the Committee, I am Cheryl Dillard, Public Affairs Director for HealthNet in Kansas City. HealthNet is a large managed care organization, financing and providing health care for 400,000 members in 93 counties in eastern Kansas and western Missouri. Over 7,000 employers offer a HealthNet HMO, PPO or other managed care product.

Thank you for the opportunity to appear before you today to oppose HB 3016, the emergency medical care mandate. First, let me begin by saying a bit about managed care. Our business is based on organizing a delivery system that provides the optimum health care-the right amount of care in the right setting at the right time. We then must develop managed care programs that will appeal to our customers-private and public employers and the people that work for them. The appeal of those programs is based on a careful mix of quality, service and cost-effectiveness. If we fail in any of those areas, our customers will "vote with their feet" and choose another plan. This prompts us to be very concerned about bills like HB 3016.

This past summer and fall, I was privileged to represent the managed care industry on Insurance Commissioner Kathleen Sebelius' Health Care Committee. The group, made up of representatives of business and labor and health care providers, had as it's charge to provide the Commissioner with broad input on health care issues that might become part of the Commissioner's legislative package. After many meetings, the Committee agreed that a major rewrite of the Kansas HMO law was called for. Senate Bill 477 is the result and has been heard in Senate Financial Institutions and Insurance Committee and assigned to a subcommittee. One new section of the law, which I've attached to my testimony, adds protections for members of managed care plans who use emergency rooms and achieves the goals of HB 3016 without the burdens of a mandate. Briefly, New Section 13 requires us to have available 24 hours a day a medical person who can evaluate over the telephone whether an emergency condition exists. We would be prohibited from denying payment for emergency medical services solely on the failure of our members to contact us prior to receiving the service. The member is given 24 hours or a reasonable period to contact us after receiving the emergency services. And, any disputes over this provision would be resolved through the plan's grievance procedure; procedures that were also strengthened through the Commissioner's proposed revision of the HMO law. We recommend that, with the probable enactment of SB 477, the legislature could test the

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also strengthened through the Commissioner's proposed revision of the HMO law. We recommend that, with the probable enactment of SB 477, the legislature could test the efficacy of this tougher approach and ask the Insurance Commissioner to evaluate it's effectiveness after a two year period.

We have two additional concerns. The ability or inability to define "prudent lay person" consistently from one managed care plan to another and from one emergency situation to another raises large and costly administrative challenges. Secondly, we strongly oppose any approach to the delivery of care that would discourage our members from connecting with their primary care physicians and, instead, to use the emergency room as their "medical home". This is especially the case as managed care plans begin to work with the Department of Social and Rehabilitative Services to serve Medicaid recipients.

Thank you. I'd be pleased to answer any questions.

At a minimum, the certificate of coverage shall include the following provisions:

(a) The definition of a grievance;

(b) how, where and to whom the enrollee should file such enrollee's grievance; and

(c) that upon receiving notification of a grievance related for payment of a bill for medical services, the health maintenance organization shall:

(1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;

(2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. If the investigation cannot be completed within 20 working days after receipt of a grievance, the enrollee shall be notified in writing within 30 working days time, and every 30 working days after that, until the investigation is completed. The notice shall state the reasons for which additional time is needed for the investigation;

(3) have within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision of the health maintenance organization regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

(4) notify, if the health maintenance organization has established a grievance advisory panel, the enrollee of the enrollee's right to request the grievance advisory panel to review the decision of the health maintenance organization. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make such enrollee's request for this review.

New Sec. 13. (a) A health maintenance organization that requires prior authorization before making payment for the treatment of medical emergency conditions, as defined by the health maintenance organization, shall provide enrollees with a toll-free telephone number answered 24 hours per day, seven days a week. At least one person with medical training who is authorized to determine whether an emergency condition exists shall be available 24 hours per day, seven days a week to make these determinations.

(b) A health maintenance organization shall not base its denial of payment for emergency medical services solely on the failure of the enrollee to receive authorization prior to receiving the emergency medical service. The enrollee must notify the health maintenance organization of receipt of medical services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event of a plan termination or termination of the participation of a provider with the plan. Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.

New Sec. 15. A health maintenance organization may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner, is accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the health maintenance organization is financially sound, and the contract contains provisions which:

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February 21, 1996

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TESTIMONY ON HOUSE BILL NO. 3016

Simply put, the goals of HMOs are to assure that the right thing is being done at the right time in the right place by the right provider. The concept of the primary care physician is one tool that HMOs have developed to help meet these goals. The primary care physician is responsible for coordinating all of his or her members medical needs, including the use of the emergency room.

HMOs have been successful in controlling medical costs through reductions in unnecessary medical care. These reductions fall into two main areas: inappropriate and unnecessary hospital care and inappropriate and unnecessary emergency room care.

Abuses in the use of the hospital emergency room have been well documented. It has been estimated that 50% of patients going to the emergency room could safely receive their care in a less costly setting. Inappropriate emergency room utilization is one of the reasons that the Medicaid program is in such dire financial straits.

There are several problems with House Bill No. 3016 as it is currently written.

1. The definition of emergency services as written is somewhat vague and could include conditions other than true emergencies. An emergency condition in one which entails a life endangering bodily injury or a sudden and unexpected serious sickness which requires a person to seek immediate medical attention under circumstances which effectively preclude them from seeking advice, treatment or authorization from their primary care physician. In these instances, we instruct our members to go to the nearest hospital emergency room.

2. An urgent condition is one which requires non-routine treatment in order to prevent a serious deterioration in one's health. These conditions can usually be treated in settings other than emergency rooms. Physicians have time in their schedules to "work in" such cases during the day. Many physicians have evening or weekend hours available to treat urgent problems. (For example, we run an urgent visit program in our offices during the week until 10:00 p.m., all day on Saturday and one-half day on Sunday.) The costs for treating these types of problems in the emergency room are enormous and unnecessary.

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3. Allowing members to self-refer to an emergency room without getting prior authorization from their primary care physician undermines the ability of HMOs to control this very expensive component of medical care.

HMOs already instruct their members on what to do in the case of an emergency. (See attached page from Humana's member handbook.) This particular bill disrupts the manner in which primary care physicians coordinate medical care, and has the potential of adding millions of dollars to health care costs for care in unnecessarily expensive settings.

Thank you.

Bruce Barter, MD

Bruce Barter, M.D.
Humana Health Care Plans

Why is "case management" important to me?

Our case management nurses act as your personal advocate any time you need hospitalization. They work with providers to arrange the most appropriate care for your needs and help you feel more at ease about hospital stays. Case management nurses also coordinate your return home or transition to recovery treatment. Case management is peace of mind for you available at no additional cost.

Am I covered for emergency care?

Absolutely. If a medical emergency is life- or limb-threatening, go to the nearest hospital emergency room. In all other cases, simply call your Humana HMO medical center or physician's office—any time, day or night. There's always a qualified medical staff member ready to help. You may either be referred to a Humana Medical Center or to the nearest Humana-affiliated hospital.

If you're admitted to the hospital under emergency conditions, your emergency room copayment is waived. If you must go to an emergency room not affiliated with Humana — even when you are away from Kansas City — you're covered. Humana Health Care Plans pays for reasonable and customary charges.

What do I do if I'm not sure my situation is an emergency?

Simply call any of our medical centers and you'll reach qualified medical professionals who can advise you. A unique feature of Humana Health Care Plans is that most medical centers also have triage nurses who can offer medical assistance over the telephone at any time. These are nurses with extensive experience in pediatric, adult and emergency room medicine.

Can I get medical attention after office hours?

Yes. We know medical problems are unpredictable and can arise at any time of the day. Should you, your child or other family member have a non-life-threatening problem after hours, simply call our Urgent Care Program. Our specially trained staff can help you arrange the care you need over the telephone. Or if you receive care through our network, you can direct inquiries to your primary care physician after office hours. This unique program is just another peace-of-mind feature of Humana Health Care Plans.

Are there eligibility requirements to join Humana Health Care Plans?

Yes. You must live in the Humana Health Care Plans enrollment area, which includes Johnson, Wyandotte, Miami and Leavenworth counties in Kansas; Jackson, Cass, Platte, Lafayette, Ray and Clay counties in Missouri. Specific information about enrollment eligibility is available from your employer.

Humana Health Care Plans offers low-cost, comprehensive benefits. Compare us to your present plan. Then make a choice that tens of thousands of Kansas Citians have made: Humana® Health Care Plans. After all, when you have your health, you have everything.

If you have questions, call us at 816-941-8003.

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Kaiser Permanente Testimony Regarding HB 3016

I am Gerard Grimaldi, public affairs director with Kaiser Permanente in Kansas City, and I appear here today to raise concerns of Kaiser Permanente with HB 3016.

Kaiser Permanente is a group model HMO with nearly 50,000 members in the Kansas City area. Kaiser Permanente operates six medical offices in the Kanas City area. As a group model HMO, Kaiser Permanente members receive their medical care from Kaiser Permanente physicians in our medical offices. Kaiser Permanente is the only HMO in the state of Kansas to receive Full Accreditation Status from the National Committee for Quality Assurance, an independent evaluator of health plans.

Kaiser Permanente operates a 24-hour advice center where members can receive immediate medical information from a nurse on duty . Our advice center logged more than half a million phone calls last year, almost 300,000 of which concerned medical advice being sought by our members. Kaiser Permanente encourages its members to contact the advice center with non-life threatening medical situations, in order that the member's care can be coordinated with their primary care physician.

In addition, Kaiser Permanente operates an Urgent Care Center in its Misssion, Kansas Medical office. Members are directed to the Urgent Care Center outside of normal business hours for medical treatment for non-life threatening situations.

Kaiser Permanente has found that use of the 24-hour advice center and the Urgent Care Center has allowed for the delivery of high value, quality medical care in urgent, but non-threatening situations. It has allowed for the coordinated care for our members in conjunction with their primary care physician. Kaiser Permanente opposes legislation that would mandate a health benefits plan to pay for the initial examination of an enrollee in an emergency room, regardless of the condition of the enrollee. Thank you, and I would be glad to answer any questions.

For more information, contact Gerard Grimaldi at 913/967-4733.

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Medevac Medical Services, Inc.
401 Jackson Street
Topeka, Kansas 66603

R.E. "Tuck" Duncan
General Counsel

To: House Committee on Health and Human Services

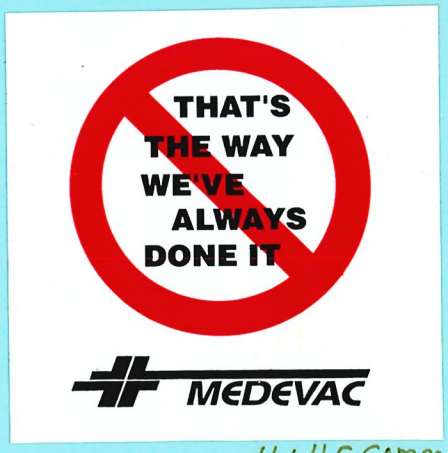
From: R.E. "Tuck" Duncan
Medevac Medical Services, Inc.

RE: HB 3016

Thank you for the opportunity to appear and comment on HB 3016. If the Committee should determine that this bill should become law, then we believe that ambulance services should also be included. The definition for emergency medical care as set forth in the bill is similar to that as set forth in various provider manuals including the Kansas SRS Ambulance Provider Manual for defining that which constitutes an emergency situation.

Further, on many occasions the first contact by a patient with emergency services is with the licensed emergency service. It seems only reasonable that the policy that applies to the hospital and the physician in this circumstance should also apply to the "eyes and hands" of these parties in the field -- the ambulance service and its paramedics and EMTs.

Therefore, we request that the bill be amended to include ambulance services as defined in 65 K.S.A. Thank you for your attention to and consideration to this matter.



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SUBSTITUTE FOR HB 2771

New Sec. 1. Prior to the legislature's consideration of any bill that changes the scope of practice of any group of health care providers which is licensed, registered or otherwise regulated by the state, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses the reasons for and the effects of the proposed change in scope of practice. For purposes of this act, "scope of practice" shall mean the services and procedures a health care provider is authorized by statute or administrative regulation to perform.

New Sec. 2. The report required under new section 1 for assessing the impact of a proposed change in scope of practice shall include at the minimum and to the extent that information is available, responses to the following:

(1) Has there been a change in the education and training of the applicant group which supports expansion of the scope of practice? Is the applicant group in practice adequately prepared through education and training to safely perform the services sought?

(2) Provide any AG's opinion or court proceeding that is relevant to the scope of practice change.

(3) How would the proposed change in scope of practice affect the cost, quality, availability or access to the service or technology;

(4) Have there been advancements in technology or practice which the applicant seeks to utilize which is prohibited or in question? Is the technology or services the applicant wishes to provide authorized under the applicant's current scope of practice?

(5) Would the desired expansion of scope of practice result in a duplication of services or increased competition and what are the disadvantages and advantages?

(6) How would the proposed change in scope of practice affect the public health, safety and welfare?

(7) What is the scope of practice and level of credentialing of the applicant group in other states?

DRAFT

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