AMERICAN NURSES ASSOCIATION
AMERICAN NURSES FOUNDATION
AMERICAN ACADEMY OF NURSING
AMERICAN NURSES CREDENTIALING CENTER
AMERICAN NURSES POLITICAL ACTION COMMITTEE

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~~CONFIDENTIAL~~

To: Jennifer Klein **Fax:** 456-2878

From: Beth Hadley **Phone:** (2) 651-7059

Date: Aug. 5 '94 **Total Pages with Cover:** 3

MESSAGE

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: MA DATE: 1-30-14

" No state may impose legal restrictions or permit practices that unnecessarily limit patient choice of, and/or prevent competition among, practitioners. Such unnecessary restrictions include, but are not limited to, limitations on prescriptive authority, supervisory or collaboration requirements mandated by state law or regulation, geographic restrictions on practice, limitations or surcharges on professional liability insurance, and limitations on institutional privileges, to the extent that any such restrictions, limitations, or surcharges are unrelated to the clinical competence of that class of practitioners. The Secretary shall promulgate regulations to implement this section."

If this first alternative language is unacceptable, we would propose the following three paragraphs as a second alternative, again coupled with the Mitchell bill's definition of "practitioner" minus the qualifying clause:

" No state may require physician or dental supervision of another practitioner who is acting within the scope of his or her license or certification.

" In any cases, disputes, or controversies raising the issue of the authorized scope of practice of a practitioner, the state licensing board for that practitioner's profession, or, in the absence of a state licensing board for that profession, the state administrative agency regulating that practitioner's profession, shall have primary jurisdiction to determine the appropriate scope of practice for that practitioner.

" Notwithstanding any state law to the contrary, no practitioner may be found to have engaged in the unauthorized practice of any other profession for performing any acts that fall within the scope of his or her license or certification."

4. We would like to make two other quick points: (1) We can support clause (b) authorizing the Secretary to promulgate regulations; and (2) if any of the groups listed in the definition of "practitioner" want to be removed from this section, we would defer to their wishes.

Again thank you for your work on this complicated issue. Please do not hesitate to call if you have any questions.

cc: Jennifer Klein
Special Assistant to the President

AMERICAN NURSES ASSOCIATION

TO: Van Dunn, M.D.
Senate Labor and Human Resources Committee

FROM: Chris deVries 202-651-7084
Beth Hadley 202-651-7059

DATE: August 5, 1994

RE: Section 1512 of the Mitchell Bill (Override of Restrictive State Practice Laws)

We are pleased that the concept of federal language prohibiting certain provisions of state law has been included in the Mitchell bill. Thank you for your hard work on this issue.

1. If it is not possible to amend the language of section 1512, we can support it as drafted.

2. If it is possible to make deletions, we would strongly urge the elimination of the qualifying clause defining "practitioner" that reads:

> " that has been awarded a master's degree or postmaster's certificate following the completion of an accredited training program that prepares individuals in advanced practitioner specialties and that is authorized by the State to practice as such a practitioner."

Because of the variation in educational requirements and licensure requirements among even these five groups of practitioners, including this qualifying clause in legislative language will create confusion about which practitioners are affected by this provision. It would be best to omit this language and leave these issues to be resolved by the Secretary through the regulatory process.

3. If it is possible to offer alternative language, we offer two proposals because we remain concerned about the phrase "beyond that which is justified by the education and training of such practitioners." We think that this phrase is a major loophole that would permit most existing restrictions to be successfully defended.

We would propose the following alternative language, coupled with the Mitchell bill's definition of "practitioner," minus the qualifying clause quoted above:

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Elizabeth Harrison Hadley, JD, MPH
Senior Policy Fellow
Department of Practice, Economics & Policy

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Chris deVries
Associate Director
Governmental Affairs

ANA: Version #1

Prohibition of discrimination in the use of health care professionals

I. Sense of Congress: (a) It is the sense of Congress that:

(1) The provision of quality health care services in this country could be achieved in a more cost-effective manner.
(2) Many third-party payors refuse to reimburse for numerous services that are competently provided by nonphysician providers.
(3) Many health plans refuse to include nonphysician providers on their panels or in their networks for reasons that are unrelated to quality of care or protection of the public.
(4) Increasing the public's access to health care services, particularly to preventive and primary care services, cannot be achieved without better utilization of nonphysician providers.
(5) Artificial legal barriers currently prevent true competition among health care professionals, limit patient choice, prevent the reasonable substitution of health care professionals in the provision of services, and force care to be delivered inefficiently and in expensive settings.
(6) The purpose of licensing health care professionals by the states is to protect the public and not to create legal monopolies that benefit any licensed profession.

II. Definitions: (a) As used in this part:

(1) Health care professional: The term "health care professional" means any individual who is licensed or otherwise authorized under state law to furnish health care items or services in the state.

(2) Third-party payor: The term "third-party payor" means any entity, public or private, that reimburses health care professionals and institutional and other providers for the provision of services to beneficiaries of a policy, contract, or program sold or administered by that entity.

(3) Provider network: The term "provider network" means the group of health care professionals chosen by a health plan or third-party payor to provide the standard benefits package, or the services covered under an insurance policy or publicly funded program, to the health plan's subscribers, or to the beneficiaries of a policy, contract, or program sold or administered by the third-party payor.

(4) Licensed: The term "licensed" means authorized by the state to perform the acts or provide the services in question. The term refers to individuals who have successfully submitted to a state process and gained state approval, either to engage in a profession as defined under state law or to use a title that is protected under state law. The term as used in this statute is to be broadly construed to include individuals who are "licensed," "certified," "registered," or otherwise authorized

under state law to engage in a profession or use a title. For purposes of this statute, a state has licensing requirements even if its process incorporates by reference, to a greater or lesser degree, the processes of private credentialing organizations or associations.

(5) Health Plan: The term "health plan" means the entity that assures payment for health care services pursuant to a written agreement. The entity may be a single organization that both assumes financial risk and directly provides health care services to its members; or it may be an organization that assumes financial risk but contracts with health care professionals or groups of health care professionals, provider networks, and institutions or groups of institutions, to provide health care services to its members. The written agreement includes but is not limited to, a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).

(6) Secretary: The term "Secretary" means the Secretary of the United States Department of Health and Human Services.

III. Obligations of Health Plans: (a) Prohibition of discrimination against any group of health care professionals: When selecting among health care professionals for membership in a provider network, a health plan shall not exclude the services, or limit the participation, of any health care professional authorized by state law to provide a covered health professional service, on the basis of the type, class, or category of health care professional. In selecting providers to participate in their provider networks, health plans shall ensure that provider networks have a sufficient number and range of health care professionals, specialties, and practice settings to provide adequate access to the standard benefit package. In selecting providers to participate in their provider networks, health plans shall use criteria that include the number, capacity, and geographic distribution of all health care professionals within the service area of that health plan.

(b) Each health plan has an obligation to deliver services in a cost-effective manner, as measured in part by the types of health care professionals that the health plan uses to deliver services.

IV. Obligations of third-party payors: (a) It shall be unlawful for any third-party payor to refuse reimbursement to any health care professional who has provided services covered by the patient's policy or contained in the standard benefits package and who, in performing such services, has acted within the scope of his profession as recognized under the law of the state where that professional is authorized to practice. A health care professional may be acting within the scope of his profession

even if the service provided is also within the authorized scope of practice of another health care professional.

(b) Third-party payors may refuse to reimburse health plans that repeatedly fail to deliver services in a cost-effective manner or repeatedly fail to use cost-effective health care professionals to deliver health services.

V. Obligations of States: (a) States shall monitor health plans to ensure that they deliver health services in a cost-effective manner and use cost-effective health care professionals to provide care, especially primary and preventive services.

(b) Notwithstanding any state law to the contrary, no health care professional may be found to have engaged in the unauthorized practice of any other profession for performing any acts that fall within the scope of his own profession as defined under state law.

(c) In any cases, disputes, or controversies raising the issue of the authorized scope of practice of a health profession, the state licensing board for that profession, or, in the absence of a state licensing board for that profession, the state administrative agency regulating that profession, shall have primary jurisdiction to determine the appropriate scope of practice for that health profession.

VI. Identification of barriers to practice: (a) In order to promote high quality health care services that are cost-effective, it is national policy that there be no group-based exclusions of any type of health care professional from participation in health plans or provider networks. The following practices contradict this national policy, whether or not they are authorized by state or federal law or regulations:

(1) Any limitations on the prescriptive authority of health care professionals who are authorized to prescribe under state law, except for those limitations established exclusively by the state licensing board or agency responsible for defining the scope of practice of that health care profession.

(2) Any provision of state law that defines the scope of practice of one health care profession, or any acts within the authorized scope of practice of a health care profession, as requiring the supervision or collaboration of a health care professional licensed in a different profession.

(3) Any provision of state law that authorizes certain activities for a given health care profession only in specified geographic locations.

(4) Any limitations on the ability of members of any health care profession to obtain professional liability insurance, including surcharges, unless those limitations are justified by actuarial

data that support the limitations on the basis of the claims experience against that profession.

(5) Any limitations on the ability of any health care professional to obtain professional liability insurance, including surcharges, that are based on that professional's decision to work with another type of health care professional, unless those limitations are justified by actuarial data that support such limitations.

(6) Any limitations on the ability of a health care professional to obtain institutional privileges appropriate to his authorized scope of practice, unless those limitations are justified by criteria other than the professional's type of license.

(b) As used in this part, "state law" means state statutes, state regulations, caselaw recognized by the courts of the state, and any rulings or opinions issued by any state agency that have the force of law.

(c) If by [insert date 5 years after enactment of this provision], a state has failed to demonstrate to the satisfaction of the Secretary that it has taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices, the Secretary is authorized to withhold federal funds, including payment for services provided to Medicare and Medicaid beneficiaries, to that state or to providers and health care professionals providing health care services in that state.

(d) The Secretary shall establish by regulation: (1) a process for having states demonstrate that they have taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices; and (2) a process for withholding federal funds to states that have failed to demonstrate to the satisfaction of the Secretary that they have failed to take such steps by [insert date 5 years after enactment of this provision.]

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4/21/94

ANA: Version # 2

" No state may impose legal restrictions or permit practices that unnecessarily limit patient choice of, and/or prevent competition among, health care professionals. Such unnecessary restrictions include, but are not limited to, limitations on prescriptive authority, supervisory or collaboration requirements in professional practice acts, geographic restrictions on practice, limitations or surcharges on professional liability insurance, and limitations on institutional privileges, to the extent that any such restrictions, limitations, or surcharges are unrelated to the clinical competence of that health profession. The Secretary shall promulgate regulations to implement this section."

ANA: Version #3

Barriers: New Suggested Provisions

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7/21/94

ANA: Version #1

Prohibition of discrimination in the use of health care professionals

I. Sense of Congress: (a) It is the sense of Congress that:

(1) The provision of quality health care services in this country could be achieved in a more cost-effective manner.
(2) Many third-party payors refuse to reimburse for numerous services that are competently provided by nonphysician providers.
(3) Many health plans refuse to include nonphysician providers on their panels or in their networks for reasons that are unrelated to quality of care or protection of the public.
(4) Increasing the public's access to health care services, particularly to preventive and primary care services, cannot be achieved without better utilization of nonphysician providers.
(5) Artificial legal barriers currently prevent true competition among health care professionals, limit patient choice, prevent the reasonable substitution of health care professionals in the provision of services, and force care to be delivered inefficiently and in expensive settings.
(6) The purpose of licensing health care professionals by the states is to protect the public and not to create legal monopolies that benefit any licensed profession.

II. Definitions: (a) As used in this part:

(1) Health care professional: The term "health care professional" means any individual who is licensed or otherwise authorized under state law to furnish health care items or services in the state.

(2) Third-party payor: The term "third-party payor" means any entity, public or private, that reimburses health care professionals and institutional and other providers for the provision of services to beneficiaries of a policy, contract, or program sold or administered by that entity.

(3) Provider network: The term "provider network" means the group of health care professionals chosen by a health plan or third-party payor to provide the standard benefits package, or the services covered under an insurance policy or publicly funded program, to the health plan's subscribers, or to the beneficiaries of a policy, contract, or program sold or administered by the third-party payor.

(4) Licensed: The term "licensed" means authorized by the state to perform the acts or provide the services in question. The term refers to individuals who have successfully submitted to a state process and gained state approval, either to engage in a profession as defined under state law or to use a title that is protected under state law. The term as used in this statute is to be broadly construed to include individuals who are "licensed," "certified," "registered," or otherwise authorized

under state law to engage in a profession or use a title. For purposes of this statute, a state has licensing requirements even if its process incorporates by reference, to a greater or lesser degree, the processes of private credentialing organizations or associations.

(5) Health Plan: The term "health plan" means the entity that assures payment for health care services pursuant to a written agreement. The entity may be a single organization that both assumes financial risk and directly provides health care services to its members; or it may be an organization that assumes financial risk but contracts with health care professionals or groups of health care professionals, provider networks, and institutions or groups of institutions, to provide health care services to its members. The written agreement includes but is not limited to, a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).

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(b) Each health plan has an obligation to deliver services in a cost-effective manner, as measured in part by the types of health care professionals that the health plan uses to deliver services.

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even if the service provided is also within the authorized scope of practice of another health care professional.

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(b) Notwithstanding any state law to the contrary, no health care professional may be found to have engaged in the unauthorized practice of any other profession for performing any acts that fall within the scope of his own profession as defined under state law.

(c) In any cases, disputes, or controversies raising the issue of the authorized scope of practice of a health profession, the state licensing board for that profession, or, in the absence of a state licensing board for that profession, the state administrative agency regulating that profession, shall have primary jurisdiction to determine the appropriate scope of practice for that health profession.

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(b) As used in this part, "state law" means state statutes, state regulations, caselaw recognized by the courts of the state, and any rulings or opinions issued by any state agency that have the force of law.

(c) If by [insert date 5 years after enactment of this provision], a state has failed to demonstrate to the satisfaction of the Secretary that it has taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices, the Secretary is authorized to withhold federal funds, including payment for services provided to Medicare and Medicaid beneficiaries, to that state or to providers and health care professionals providing health care services in that state.

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ANA: Version #3

Barriers: New Suggested Provisions

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(c) If by [insert date 5 years after enactment of this provision], a state has failed to demonstrate to the satisfaction of the Secretary that it has taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices, the Secretary is authorized to withhold federal funds, including payment for services provided to Medicare and Medicaid beneficiaries, to that state or to providers and health care professionals providing health care services in that state.

(d) The Secretary shall establish by regulation: (1) a process for having states demonstrate that they have taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices; and (2) a process for withholding federal funds to states that have failed to demonstrate to the satisfaction of the Secretary that they have failed to take such steps by [insert date 5 years after enactment of this provision.]

MEMORANDUM

TO: Brian Biles, Jennifer Klein

FROM: Bob St. Peter

DATE: June 23, 1994

SUBJ: restrictive state practice laws

Attached is the latest draft of the language on override of restrictive state practice laws. It reflects a few changes from the previous draft which you both reviewed. First, it does not specify exactly which practitioners are covered by this clause (going back to the original HSA language). We need to know from you who are the groups that are most invested in this? David didn't want to list providers and risk making some angry that they are in and some angry that they are out. We have been receiving letters from groups like physical therapists and lab technicians that do NOT want this language in the bill. Who are the groups that DO want this in, and do you think we should be more explicit in limiting it to these groups? Or do you favor leaving it very broad? We assume that nurse practitioners, CNMs, nurse anesthetists, clinical nurse specialists, and PAs are the ones invested.

Secondly, the issue of the ability of Federal law to limit a state's ability to enforce or establish laws of this type was worrisome to some. The language has been changed so that the Secretary is expected to determine compliance with the regulations. Does this have enough teeth in it to do what we want it to do? Are there better options? Your input would be appreciated. Please call me or Van with any comments. Thanks.

6/9

DRAFT 6/23

AMENDMENT NO. ___ Calendar No. ___

Purpose: To clarify the application of provisions relating to preemption of State practice laws.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.___

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _ _____ _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

Strike section 1161 and insert the following new section:

SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS. (1)

(a) GENERAL RULE.—No State may, through licensure or otherwise, restrict the practice of practitioners beyond that which is justified by the education and training of such practitioners.

(2) - See insert

Why took out "Classic" language?

(b) REGULATIONS.—

(1) IN GENERAL.—The Secretary shall promulgate regulations to implement subsection (a). In establishing such regulations, the Secretary shall include in the notices published under this section a description of State policies that are determined to restrict the practice of practitioners beyond that which is justified by the education and training of such practitioners. In developing such regulations the Secretary shall consult with National and State licensing boards with jurisdiction over such practitioners.

How does the digest show this?

NLNursing?

(2) PRELIMINARY NOTICE.—Not later than July 1, 1996, the Secretary shall publish in the Federal Register a preliminary notice of the regulation under paragraph (1) for public comment.

(3) FINAL NOTICE.—Not later than December 31, 1996, the Secretary shall publish a final notice of the regulations under paragraph (1) that takes into consideration public comments received.

(c) PROHIBITION.—Effective on the date that is 2 years after the date of the publication of the final notice under subsection (b)(3), the Secretary shall develop and implement procedures to determine whether a State is in

compliance with the regulations promulgated under subsection (b).

(d) DIGEST OF LAWS.—

(1) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary shall develop a digest of State laws, regulations and practices pertaining to the licensure and scope of practice of practitioners.

(2) ANNUAL UPDATES.—The digest under paragraph (1) shall be updated at least annually.

(3) CONTENTS.—The digest under paragraph (1) shall indicate which State laws, regulations and practices appear to unduly restrict the scope of practice for practitioners.

(4) LEGAL ASSISTANCE.—The Secretary shall ensure that appropriate technical assistance is available to States for the purpose of complying with the provisions of this section.

Insert into (a):

(2) DEFINITION.— As used in this section, ~~the~~ term "practitioner" means a health care provider that is authorized by the State to practice as such a practitioner.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 8

To Jennifer Klein | From Sharman Stephens

Dept./Agency | Phone #

Fax # | Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

DRAFT

TO: Jen Klein
FROM: Sharman Stephens, Lisa Rovin
RE: Health Professions Related Provisions In HSA
DATE: June 28, 1994

I. Background: The HSA Provisions

The HSA contains four provisions related to health professionals:

(1) **Section 1112. Services of Health Professionals** - defines health professional to mean "an individual who provides health professional services." The term "health professional services" is then defined to mean "professional services that -- (A) are lawfully provided by a physician; or (B) would be described in subparagraph (A) if provided by a physician, but are provided by another person who is legally authorized to provide such services in the State in which the services are provided."

(2) **Section 1161. Override of Restrictive State Practice Laws** - "No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals."

(3) **Section 1322(b)(2) Fee-For-Service Plan Defined** - defines a FFS plan as a plan that "(i) provides coverage for all items and services included in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice . . . (ii) makes payment to such a provider without regard to whether or not there is a contractual arrangement between the plan and the provider.

(4) **Section 1407. Preemption of Certain State Laws Relating to Health Plans** - exempts non fee-for-service plans or components of plans from state laws which prohibit or restrict plans from limiting the number and type of health care providers who participate in the plan.

II. Issues

These provisions, and the interactions between them, have raised a number of issues, including:

A. How can it be determined what services are justified by a professional's "skills and training"?

· Litigation. It is unclear how to determine what services are justified by a professional's "skills and training." This would invite litigation, which would (1) be expensive, and (2) leave clinical judgements to the courts (arguably the least qualified to make such determinations).

· Federalization. The lack of clarity in this phrase has already invited attempts to create federal practice standards (we have seen language from two committees which would have this effect). The Federal government has traditionally left the responsibility for health professional licensure and regulation to states. The movement to establish federal practice standards would represent a significant change in federal policy and role.

B. These provisions make fee-for-service plans vulnerable to the claims of any health-related provider with a state license (e.g., dance therapists, herbalists). There is concern that the openness of the provision will result in either the fee schedule inadequately paying traditional health professionals (e.g., physicians) and thus the lack of providers participating in fee-for-service plans, or the unwillingness of insurers to offer fee-for-service plans.

C. There are fears that these provisions could be used to argue that certain health professionals are granted an entitlement to be paid for any services they lawfully render by any health plan. For example, if a managed care plan choses to cover local anesthesia when rendered by a physician but not when rendered by a nurse anesthetist, could the NA's sue under these provisions?

II. Possible Solutions

In response to these issues, staff have attempted to "brainstorm" other possible approaches to dealing with health professions.

The HSA took the approach of not naming specific professionals other than physicians. The major alternative approaches that have been identified would involve specifying types of health professionals. The actual vehicle for specifying the professionals can vary, to be more or less consistent with the stated goals of the current HSA structure.

Similarly, the HSA assumes that federal action is necessary to pre-empt restrictive state laws (in large part because the local medical societies are more effective lobbying at the state level than the representatives of potential competing professionals). However, in recent meetings we have heard concerns from nonphysician health professional groups which compete with one another. Certain therapists' groups may worry that nurses are encroaching on their territory, lab techs may not want uncertified persons encroaching on their functions, dentists fear competition from hygienists, etc. In light of these concerns, we may want to revisit our original thinking.

Option 1: Modify Benefit Package to List Covered Health Professions and Eliminate the Override

While this is clearly an option, it is the most inconsistent with the original thrust of the HSA, which is not to name specific health professionals in the benefit package. The HSA intent has been to encourage efficient delivery of care under private health insurance. Because the incentive of the HSA is for insurance plans to deliver care more effectively, plans will be encouraged to select those services and professionals that efficiently promote health. It is thought that this flexibility, supported by quality performance reports that tell consumers and providers about health outcomes and consumer satisfaction, will broaden opportunities for a broad range of health professionals in a reformed health care system. If health professionals were specifically named in the HSA benefit package the incentives to move to a broader array of health professionals would be stymied.

In listing the specific professionals to be covered in the benefit package some of the need for the override is lessened, since the specific practitioners who are eligible for reimbursement are named.

Option 2: Do Not Change the Health Professions Language in the Benefit Package; Amend the Definition of FFS Plan to Specify the Minimum Set of Professionals that a FFS Plan Must Provide Access To; and Eliminate the Override Provision

By not changing the benefit package health professions provision the incentives for efficient use of health professionals remains, and the evolving nature of services delivery is not stymied. Changing the definition of FFS to specify a minimum set of professionals to be covered protects FFS plans from claims for entitlement to reimbursement from service providers not currently part of the typical health insurance market. The minimum specification approach does not preclude a FFS health plan from then choosing other efficient and effective health providers.

> (Note: The language in the definition might need to be something like "provides coverage for all items and services included in the comprehensive benefit package that are furnished or ordered by a physician or by . . . (specified list of other health professionals).")

Again since specific practitioners are named within the context of FFS some of the need for the override provision is lessened, and its elimination would help to avoid some of the problems that have been identified.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▶ 8 1

See correction

To. Jennifer Klein	From Sharman Stephens
Dept./Agency	Phone #
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Option 3: Do Not in the Benefit Package; Amend the Override Provision to Specify the Professional Groups to Which it Applies; and Define the FFS Plan to Provide Access to the Health Professionals Covered by the Override Provision

This option was developed in response to the potential political need to retain the override provision. By specifying the professional groups covered by the override at least the complete openness of the current override provision is curtailed.

Option 4: Amend Only the Override Provision to Specify a Limited Number of Professional Groups to Which it Applies

This option is similar to option three but avoids getting into the area of specifying types of providers eligible for fee-for-service reimbursement. This approach addresses the specific issue raised most strongly by the two professional groups (nurses and psychologists), without involving more controversial measures. However, it then does not address the issue of the openness of the benefits package and the vulnerability of fee-for-service plans.

Option 5: Eliminate the Override Provision Only

This option would avoid listing professionals. It would not curtail the openness of the benefits package provisions, but at least it would prevent further expansion of covered providers. In addition, listing only certain professionals implies that we condone state limits on the scope of practice of other practitioners beyond the limits inherent in their skills and training. It may be better to drop the preemption altogether than to preempt for only certain licensed professionals and leave other licensed professionals worse off than before reform.

III. Specifying Health Professionals

If Option 1, 2, or 3 or 4 is chosen, which health professionals should be specified and what is the rationale for the selection?

While the identification of specific health professionals will cause controversy, to the extent that the list chosen incorporates the major health professional groups currently eligible for health insurance reimbursement there is less likely to be significant problems.

Furthermore, as the problems of the override are becoming more apparent there may be support for some better delineation of the health professions involved. If either options 2 or 3 or 4 from above

(i.e., do not specify the professions in the benefit package) are selected the case can be made that these modifications do not alter the incentives for health care plans, and in particular managed health care plans, to select those services and professionals that efficiently promote health. The Options 2 and 3 modifications proposed do not change the opportunity to broaden the range of health professionals in a reformed health care system.

Three major options for selection have been identified. Rather than relying on one single approach, it might be possible to justify an approach that looked for commonality between the various listings. In addition, depending upon which of the above options is selected the specific list of professionals may change. For example, the appropriate list for the benefit package might be different than that for preemption.

Option 1 -- Medicare. Use existing Medicare providers who can independently bill for services. However, there is some concern about basing the selection on Medicare because Medicare limits the services which nonphysician health professionals may provide and the circumstances under which they may be paid. These limitations may be appropriate for Medicare, because Medicare pays providers directly on a fee-for-service basis. They are less apt for purposes of defining covered benefits (or the scope of a federal preemption) in a reformed health care system intended to give health plans more leaway in determining the mix of health professionals which best meet their enrollees' needs.

Medicare provides direct billing for the following types of professionals:

a. physicians, and the following professionals which are included in the definition of physician:
   - dentists
   - optometrists
   - podiatrists
   - chiropractors

b. Medicare's billing rules also include coverage for:
   - physician assistants
   - nurse practitioners
   - clinical nurse specialist
   - nurse-midwives
   - certified registered nurse anesthetists
   - clinical psychologists
   - clinical social workers
   - physical and occupational therapists working in an independent practice (In order for services to be covered patient must be under the care of physician with plan of care periodically reviewed by physician.

There is a $ limit on what can be billed under independent practice.)

Note: speech therapy cannot be done in independent practice under Medicare

Option 2 -- Blue Cross/Blue Shield FEHBP. Use existing BC/BS FEHBP. This essentially yields a vary similar group of professionals except for physician assistants, physical therapists, and occupational therapists.

a. physicians, which BC/BS defines as doctors of:
   - medicine
   - osteopathy
   - dental surgery (D.D.S)
   - medical dentistry (D.M.D.)
   - podiatric medicine
   - optometry

b. other covered providers who may render services without the supervision of a physician
   - qualified clinical psychologist
   - nurse midwife
   - nurse practitioner/clinical specialist
   - clinical social worker

c. in medically underserved areas (which are certain designated states) BC/BS goes on to include any licensed medical practitioner when performing covered services within the scope of their license or certification

Option 3 -- Most Common State Mandates

The 1992 "Mandated Benefits Manual" produced by Scandlen Publishing, Inc. reports the following:

Covered Providers	Number of States With Mandated Benefits
Optometrists	46
Chiropractors	45
Dentists	43
Psychologists	39
Podiatrists	37
Social Workers (LCSWs)	23
Osteopaths	19
Nurse Midwives (CNMs)	19
Nurse Practitioners	17

Nurses (RNs)	12
Licensed Health Professionals	10
Nurse Anesthetists (CRNAs)	9
Nurses, Psychiatric	9
Professional Counselors	8
Speech Therapists	8
Acupuncturists	7
Physical Therapists	7
Occupational Therapists	5
Oral Surgeons	3
Naturopaths	2

DRAFT

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▸ 4

To Jennifer Klein	From Sharman Stephens
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

The Honorable Barbara A. Mikulsk
United States Senate
Washington, D.C. 20510-6300

Dear Senator Mikulski:

Thank you for your letter regarding our earlier correspondence on the role of alternative health care providers, such as acupuncturists. I am pleased you found the previous information helpful.

As to your request about covered alternative health care modalities, the President's Health Security Act (the HSA) specifies a broad range of medically necessary or appropriate services in the benefit package, including such services as inpatient and outpatient hospital care, clinical preventive services, mental illness and substance abuse services, outpatient rehabilitation services, hospice care, home health care, extended care, and services of health professionals. The HSA does not specify the particular types of health professionals who can provide covered services. As is the case today these decisions are left to States through licensure and health plans through negotiations with providers. Under the HSA, States would continue to maintain their licensure and certification role. The President's plan does not envision a role for health alliances in the determination of covered services and professionals.

The intent of the HSA is to encourage efficient delivery of care through private health insurance. It is our hope that as we change incentives for insurance plans to deliver care more effectively, plans will be encouraged to select those services and professionals that effectively and efficiently promote health. We believe that this flexibility, supported by quality performance reports that tell consumers and providers about health outcomes and consumer satisfaction, will broaden opportunities for a broad range of health professionals in a reformed health care system.

You also asked about how determinations of "medical necessity" are to made. It is the intention of the HSA to cover those services that are medically necessary or appropriate and that these decisions remain primarily between providers and their patients. As you know, both public and private payers currently use the concept of medical necessity in making coverage determinations and it is expected that this practice would continue under health reform. In addition, the HSA provides authority for the National Health Board to promulgate regulations regarding items or services that the Board determines are not medically necessary or appropriate. The Board may also promulgate regulations or establish guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans. Finally,

Jen appreciate your review of

it is important to note that the HSA provides specific provisions for review of benefit determinations for persons dissatisfied with health plans determinations of coverage.

Finally, with regard to your inquiry about qualifications for health plan "gate keepers," you are correct that the President's Health Security Act does not "mandate that approval be given by an allopathic physician or allopathically trained nurse, nor that allopathic medical criteria be used for approval." The HSA does require that health plans disclose the protocols used by the plan for controlling utilization and costs. As part of the HSA's quality management and improvement provisions, development of procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization is included as one of the areas for the dissemination of practice guidelines.

I hope that this information is helpful. I appreciate your interest in health care reform, and look forward to continued discussions with you as we work with Congress to assure that every American is guaranteed access to comprehensive quality care through private insurance.

Sincerely yours,

Donna E. Shalala

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:
APPROPRIATIONS
SELECT COMMITTEE ON ETHICS
LABOR AND HUMAN RESOURCES

United States Senate

WASHINGTON, DC 20510-2003

SUITE 709
HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-2003
(202) 224-4654
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June 8, 1994

The Honorable Donna E. Shalala
Secretary, Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

Thank you for your prompt response to my letter of April 25, 1994, with regard to the role alternative health care providers, such as acupuncturists, would have under the President's health care plan. I have conveyed your response to the acupuncture community in a presentation I made to their national convention on April 29 in Crystal City.

Discussions following that meeting have focused several concerns about which I seek your clarification. I understand the President's plan to mean that:

1. Determination as to whether alternative health care modalities are covered is to be made at the state level or by a particular insurance alliance or program. Such determinations would be made on the basis of research demonstrating cost effectiveness of outcomes.

2. Services are covered when they are determined to be beneficial to the restoration or maintenance of good health for an individual and that the words "medical necessity" are understood in the sense of benefit to the health of the patient and are not limited to currently understood determinations of allopathic medicine.

3. While individual health plans may keep the role of gate keeper and require prior approval for referral to an alternative health care provider, there is no mandate that approval be given by an allopathic physician or allopathically trained nurse, nor that allopathic medical criteria be used for approval.

4. Determination of whether such practices are used would not be a function of the national health board established by the President's plan.

I would appreciate your confirmation of my understanding of these issues.

Sincerely,

Barbara A. Mikulski
Chair, Subcommittee on Aging
Committee on Labor and
Human Resources

American Nurses Association

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Virginia Trotter Betts, JD, MSN, RN
President

Shirley A. Girouard, PhD, RN, FAAN
Executive Director

TO: Jennifer L. Klein
Special Assistant to the President

FROM: Chris deVries
Governmental Affairs
(202) 651-7084
FAX 554-0189

Beth H. Hadley
Policy, Economics, & Practice
(202) 651-7059

DATE: June 10, 1994

RE: Section 1161

I understand you are working on the "override" provision in the Health Security Act that pertains to restrictive state practice acts for health care providers. As there has been a lot of confusion over this issue, I want to share with you some of the discussions we have had with the Senate Labor and Human Resources Committee on this issue.

As written, Section 1161 is vague, at best. The American Nurses Association (ANA) is in support of language in health care reform that would 1) ensure that health plans could not discriminate against any type or class of provider and 2) remove arbitrary barriers to practice for advanced practice nurses. For these reasons, we developed specific language to address these two issues (see attachments). However, Section 1161 as drafted, does not accomplish that task.

It is our understanding, however, that some Administration and Congressional representatives are examining whether Section 1161 (override) should be restricted to advanced practice nurses and physician assistants and that the Federal override in terms of state practice laws should be specified. ANA agrees with that interpretation or alteration of the override section. We have developed specific language pertaining to the barriers that advanced practice nurses face within state law that are not related to their ability to deliver services or their educational level. In addition, we have drafted some brief "talking points" on why the Federal government should override state law in this particular instance. I hope you find this material useful.

Please do not hesitate to call either Beth or me at the above numbers, if we can be of any additional assistance.

Thank you.

Attachments: (3)
cc: Becky Franck

(Taken from draft language developed by ANA on non-discrimination toward health care providers and barriers to practice)

VI. Identification of barriers to practice: "(a) In order to promote high quality health care services that are cost-effective, it is national policy that there be no group-based exclusions of any type of health care professional from participation in health plans or provider networks. The following practices contradict this national policy, whether or not they are authorized by state or federal law or regulations:

(1) Any limitations on the prescriptive authority of health care professionals who are authorized to prescribe under state law, except for those limitations established exclusively by the state licensing board or agency responsible for defining the scope of practice of that health care profession.

(2) Any provision of state law that defines the scope of practice of one health care profession, or any acts within the authorized scope of practice of a health care profession, as requiring the supervision or collaboration of a health care professional licensed in a different profession.

(3) Any provision of state law that authorizes certain activities for a given health care profession only in specified geographic locations.

(4) Any limitations on the ability of members of any health care profession to obtain professional liability insurance, including surcharges, unless those limitations are justified by actuarial data that support the limitations on the basis of the claims experience against that profession.

(5) Any limitations on the ability of any health care professional to obtain professional liability insurance, including surcharges, that are based on that professional's decision to work with another type of health care professional, unless those limitations are justified by actuarial data that support such limitations.

(6) Any limitations on the ability of a health care professional to obtain institutional privileges appropriate to his authorized scope of practice, unless those limitations are justified by criteria other than the professional's type of license.

(b) As used in this part, "state law" means state statutes, state regulations, caselaw recognized by the courts of the state, and any rulings or opinions issued by any state agency that have the force of law.

(c) If by [insert date 5 years after enactment of this provision], a state has failed to demonstrate to the satisfaction of the Secretary that it has taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices, the Secretary is authorized to withhold federal funds, including payment for services provided to Medicare and Medicaid beneficiaries, to that state or to providers and health care professionals providing health care services in that state.

(d) The Secretary shall establish by regulation: (1) a process for having states demonstrate that they have taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices; and (2) a process for withholding federal funds to states that have failed to demonstrate to the satisfaction of the Secretary that they have failed to take such steps by [insert date 5 years after enactment of this provision.]"

Following are some "talking points" on the need for the removal of these barriers

* State licensure laws create enormous inefficiencies in the health care market. Nevertheless because the licensure of health professionals is traditionally the domain of the states, there are steps short of pre-emption that the Federal government can take to encourage the better use of health professionals. The Federal government has a strong interest in doing this action because of its role as a primary payer and player in the health care market.

* The standards for each health care profession are increasingly becoming national rather than local standards. In medicine, for example, the "community standard" of appropriate care has been increasingly eroded in malpractice cases. The same logic applies to other health care professions (i.e., what is appropriate care does not vary from state to state). For this reason, it makes sense to have the Federal government set some guidelines with respect to licensure.

* State licensure laws often prevent nurses from functioning as substitutes for physicians in many situations where more than one health care professional could treat the patient. This situation is especially true for primary care services where numerous studies have concluded that much of the primary care delivered by physicians could be delivered by advanced practice nurses.

* Requiring supervision of an advanced practice nurse by another professional category increases the expense of any services delivered since the physician will have to be reimbursed for the supervisory of collaborative responsibility, regardless of whether this requirements adds any value to the advanced practice nursing services.

* It is antithetical to a concept of a profession to have the professional legally defined in statute or regulation as requiring the supervision of another professional. For example, a statutory or regulatory requirement of supervision or collaboration leaves unclear whether prescribing is within an advanced practice nurse's authorized scope of professional practice. These kinds of legal requirements confuse the state of the law and increase the cost of health care.

* Any state laws that restricts the advanced practice nurse's ability to receive reimbursement based on a geographic or site restriction (i.e., rural versus urban; nursing home versus hospital) is completely unrelated to the competence of that advanced practice nurse and should be prohibited by Federal law. If a nurse is a competent to perform a service in one setting, she is completely competent in another health care delivery site.

* The greater use of advanced practice nurses will not necessarily increase health care costs because: (i) many of these services are already performed by the advanced practice nurse, but are billed for by the physician at the physician's rate; (ii) studies have shown that advanced practice nurses are highly cost effective, especially when delivering primary care; and (iii) the increased demand for services that will result from universal coverage cannot be met without better utilization of advanced practice nurses and it will cost more to meet this new demand if physician services are solely relied upon.

ANA proposed language

ATTACHMENT THREE

Prohibition of discrimination in the use of health care professionals

I. Sense of Congress: (a) It is the sense of Congress that:

(1) The provision of quality health care services in this country could be achieved in a more cost-effective manner.
(2) Many third-party payors refuse to reimburse for numerous services that are competently provided by nonphysician providers.
(3) Many health plans refuse to include nonphysician providers on their panels or in their networks for reasons that are unrelated to quality of care or protection of the public.
(4) Increasing the public's access to health care services, particularly to preventive and primary care services, cannot be achieved without better utilization of nonphysician providers.
(5) Artificial legal barriers currently prevent true competition among health care professionals, limit patient choice, prevent the reasonable substitution of health care professionals in the provision of services, and force care to be delivered inefficiently and in expensive settings.
(6) The purpose of licensing health care professionals by the states is to protect the public and not to create legal monopolies that benefit any licensed profession.

II. Definitions: (a) As used in this part:

(1) Health care professional: The term "health care professional" means any individual who is licensed or otherwise authorized under state law to furnish health care items or services in the state.

(2) Third-party payor: The term "third-party payor" means any entity, public or private, that reimburses health care professionals and institutional and other providers for the provision of services to beneficiaries of a policy, contract, or program sold or administered by that entity.

(3) Provider network: The term "provider network" means the group of health care professionals chosen by a health plan or third-party payor to provide the standard benefits package, or the services covered under an insurance policy or publicly funded program, to the health plan's subscribers, or to the beneficiaries of a policy, contract, or program sold or administered by the third-party payor.

(4) Licensed: The term "licensed" means authorized by the state to perform the acts or provide the services in question. The term refers to individuals who have successfully submitted to a state process and gained state approval, either to engage in a profession as defined under state law or to use a title that is protected under state law. The term as used in this statute is to be broadly construed to include individuals who are "licensed," "certified," "registered," or otherwise authorized under state law to engage in a profession or use a title. For

purposes of this statute, a state has licensing requirements even if its process incorporates by reference, to a greater or lesser degree, the processes of private credentialing organizations or associations.

(5) Health Plan: The term "health plan" means the entity that assures payment for health care services pursuant to a written agreement. The entity may be a single organization that both assumes financial risk and directly provides health care services to its members; or it may be an organization that assumes financial risk but contracts with health care professionals or groups of health care professionals, provider networks, and institutions or groups of institutions, to provide health care services to its members. The written agreement includes but is not limited to, a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).

(6) Secretary: The term "Secretary" means the Secretary of the United States Department of Health and Human Services.

III. Obligations of Health Plans: (a) Prohibition of discrimination against any group of health care professionals: When selecting among health care professionals for membership in a provider network, a health plan shall not exclude the services, or limit the participation, of any health care professional authorized by state law to provide a covered health professional service, on the basis of the type, class, or category of health care professional. In selecting providers to participate in their provider networks, health plans shall ensure that provider networks have a sufficient number and range of health care professionals, specialties, and practice settings to provide adequate access to the standard benefit package. In selecting providers to participate in their provider networks, health plans shall use criteria that include the number, capacity, and geographic distribution of all health care professionals within the service area of that health plan.

(b) Each health plan has an obligation to deliver services in a cost-effective manner, as measured in part by the types of health care professionals that the health plan uses to deliver services.

IV. Obligations of third-party payors: (a) It shall be unlawful for any third-party payor to refuse reimbursement to any health care professional who has provided services covered by the patient's policy or contained in the standard benefits package and who, in performing such services, has acted within the scope of his profession as recognized under the law of the state where that professional is authorized to practice. A health care professional may be acting within the scope of his profession even if the service provided is also within the authorized scope

of practice of another health care professional.

(b) Third-party payors may refuse to reimburse health plans that repeatedly fail to deliver services in a cost-effective manner or repeatedly fail to use cost-effective health care professionals to deliver health services.

V. Obligations of States: (a) States shall monitor health plans to ensure that they deliver health services in a cost-effective manner and use cost-effective health care professionals to provide care, especially primary and preventive services.

(b) Notwithstanding any state law to the contrary, no health care professional may be found to have engaged in the unauthorized practice of any other profession for performing any acts that fall within the scope of his own profession as defined under state law.

(c) In any cases, disputes, or controversies raising the issue of the authorized scope of practice of a health profession, the state licensing board for that profession, or, in the absence of a state licensing board for that profession, the state administrative agency regulating that profession, shall have primary jurisdiction to determine the appropriate scope of practice for that health profession.

VI. Identification of barriers to practice: (a) In order to promote high quality health care services that are cost-effective, it is national policy that there be no group-based exclusions of any type of health care professional from participation in health plans or provider networks. The following practices contradict this national policy, whether or not they are authorized by state or federal law or regulations:

(1) Any limitations on the prescriptive authority of health care professionals who are authorized to prescribe under state law, except for those limitations established exclusively by the state licensing board or agency responsible for defining the scope of practice of that health care profession.

(2) Any provision of state law that defines the scope of practice of one health care profession, or any acts within the authorized scope of practice of a health care profession, as requiring the supervision or collaboration of a health care professional licensed in a different profession.

(3) Any provision of state law that authorizes certain activities for a given health care profession only in specified geographic locations.

(4) Any limitations on the ability of members of any health care profession to obtain professional liability insurance, including surcharges, unless those limitations are justified by actuarial data that support the limitations on the basis of the claims

experience against that profession.

(5) Any limitations on the ability of any health care professional to obtain professional liability insurance, including surcharges, that are based on that professional's decision to work with another type of health care professional, unless those limitations are justified by actuarial data that support such limitations.

(6) Any limitations on the ability of a health care professional to obtain institutional privileges appropriate to his authorized scope of practice, unless those limitations are justified by criteria other than the professional's type of license.

(b) As used in this part, "state law" means state statutes, state regulations, caselaw recognized by the courts of the state, and any rulings or opinions issued by any state agency that have the force of law.

(c) If by [insert date 5 years after enactment of this provision], a state has failed to demonstrate to the satisfaction of the Secretary that it has taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices, the Secretary is authorized to withhold federal funds, including payment for services provided to Medicare and Medicaid beneficiaries, to that state or to providers and health care professionals providing health care services in that state.

(d) The Secretary shall establish by regulation: (1) a process for having states demonstrate that they have taken all legal steps necessary to eliminate the anticompetitive practices specified above, including amending state law that creates or authorizes any such practices; and (2) a process for withholding federal funds to states that have failed to demonstrate to the satisfaction of the Secretary that they have failed to take such steps by [insert date 5 years after enactment of this provision.]

EHH:g:\ehh\antidisc.leg
4/21/94

PAUL D. WELLSTONE
MINNESOTA

United States Senate

WASHINGTON, DC 20510-2303

456 2878

FROM THE OFFICE OF SENATOR PAUL DAVID WELLSTONE

FAX COVER SHEET

TO: JENNIFER KLEIN

FROM: ELLEN SHAFFER

DATE: 6/8

MESSAGE: PER YR. REQUEST RE:
WELLSTONE DUE PROCESS AMENDMENT

COVER SHEET + _____ PAGES = _____ TOTAL PAGES

QUESTIONS/PROBLEMS, PLEASE CALL 202-224-5641
FAX 202-224-8438

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide due process for health care providers.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. WELLSTONE

Viz:

After section 5215, insert the following new section:

SEC. 5216. DUE PROCESS FOR HEALTH CARE PROVIDERS.

(a) PUBLICLY AVAILABLE STANDARDS AND PROCESS.—Each health plan shall establish and utilize—

(1) publicly available standards for contracting with health care providers; and

(2) a publicly available process for dismissing such providers or failing to renew contracts with such providers.

(b) NOTICE REQUIREMENT.—

(1) IN GENERAL.—The process established by a health plan under subsection (a) shall include ~~notify-~~ reasonable notification to ~~ing~~ a health care provider of a decision to dismiss such provider or not to renew a contract with such provider ~~not later than 60 days~~ before such decision takes effect.

(2) EXCEPTION.—The notice required under paragraph (1) shall not apply if failure to dismiss a provider or renewing a provider's contract would adversely affect the health or safety of a patient.

(3) CONTENTS OF NOTICE.—Each notice to a health care provider under paragraph (1) shall contain the reasons for the dismissal or failure to renew. Such reasons shall be consistent with the standards established under subsection (a).

(c) REVIEW.—The process established by a health plan under subsection (a) shall include an opportunity for review of the health plan's action by a health care provider who is dismissed by a health plan or with respect to whom a health plan fails to renew a contract. Such review shall be conducted by—

(1) the provider's peers who have contracts with, or are employed by, the health plan; and

(2) if there is mutual consent of the provider and the health plan, one or more enrollees in the health plan.

A health care provider may have an attorney present in connection with any review under this subsection if the provider notifies the health plan that an attorney will be present in advance of the review proceeding.

(d) EFFECT ON OTHER LAWS.—The provisions of this section shall not supersede any other provision of Federal or State law.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To clarify the application of provisions relating to preemption of State practice laws.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

Strike section 1161 and insert the following new section:

SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS.

(a) GENERAL RULE.—

(1) LIMITATION.—No State may, through licensure or otherwise, restrict the practice of practitioners (as defined in paragraph (2)) beyond that which

is justified by the ~~skills~~ education and training of such practitioners.

(2) DEFINITION.—As used in this section, the term "practitioner" means—

(A) a nurse practitioner;

(B) a certified nurse midwife;

(C) a nurse anesthetist;

(D) a clinical nurse specialist;

(E) a physicians assistant; and

(F) any other health professional as determined to be appropriate by the Secretary;

for practitioners in paragraphs A-D

that has been awarded a master's degree or postmaster's certificate following the completion of an accredited training program that prepares individuals in advanced practitioner specialties and that is authorized by the State to practice as such a practitioner.

and in the case of practitioners in (E) have completed an accredited training program for physician assistants,

should apply to all types

(b) STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish minimum standards applicable to practitioners under State practice acts. In establishing such standards, the Secretary shall include in the notices published under this section a description of State policies that are determined to restrict the practice of practition-

The Sec. shall issue regs.

is this the term we want to use

ers beyond that which is justified by the education and training of such practitioners. In developing these standards the Sec shall consult with State and national licensing boards with jurisdiction over such practitioners.

(2) PRELIMINARY NOTICE.—Not later than July 1, 1996, the Secretary shall publish in the Federal Register a preliminary notice of the standards under paragraph (1) for public comment.

(3) FINAL NOTICE.—Not later than December 31, 1996, the Secretary shall publish a final notice of the standards under paragraph (1) that takes into consideration public comments received.

(c) PROHIBITION.—

(1) IN GENERAL.—Effective on the date that is 2 years after the date of the publication of the final notice under subsection (b)(3), a State shall not establish or enforce any law or regulation of the type specified in the final notice of the Secretary as restricting the practice of a practitioner beyond that which is justified by the education and training of such professional.

(1) Sec. directs States in violation or (2) take case out. → go to state ct -- fed law governs.

~~(2) CIVIL SUIT.—After the date referred to in paragraph (1), any individual or other party who is adversely affected by a State law or regulation unreasonably restricting the scope of practice of a practitioner may commence a civil suit to enforce this section.~~

Strike

(d) DIGEST OF LAWS.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall develop a digest of State laws, regulations and practices pertaining to the licensure and scope of ~~practice~~ practitioners.

(2) ANNUAL UPDATES.—The digest under paragraph (1) shall be updated at least annually.

(3) CONTENTS.—The digest under paragraph (1) shall indicate which State laws, regulations and practices appear to unduly restrict the scope of practice for practitioners.

(4) LEGAL ASSISTANCE.—The Secretary shall ensure that appropriate ~~legal consultative~~ technical assistance is available to States for the purpose of complying with the provisions of this section.

Changing the phrase "any class of health professionals" to a list of specified health professionals is unwise and unnecessary:

- "Health professional" is defined in § 1112 to include only those professionals licensed by the state. Thus, in each state it will be clear who is covered by the preemption.

- Listing only certain professionals implies that we condone state limits on the scope of practice of other practitioners beyond the limits inherent in their skills and training. It may be better to drop the preemption altogether than to preempt for only certain licensed professionals and leave other licensed professionals worse off than before reform.

Including a directive that states not limit scope of practice beyond the "skills and training" of the practitioner:

- Gives support to state legislatures to base their scope of practice decision on clinical competencies, not political pressures.

- Allows evolution of health professional competencies.

- There may be a better standard than "skills and training." But the problem is not solved by listing professionals.

Federal standards for any health practitioner are inappropriate:

- States have always had authority to do health and safety regulation for their residents. Regulation of health provider licensure has long been part of state health and safety regulation.

- States are in a better position to set these standards. If the feds set standards for scope of practice, it could entangle them in other messy -- and very local -- issues (licensure, withdrawal of licensure, etc).

- Physicians take national certification examinations, but we still leave it to states to regulate the practice of medicine. We should not provide for different treatment advanced practice nurses.

- The legal issues created with federal standards would be unavoidably messy. This invites lawsuits, but the courts are the least qualified to be making these judgements (i.e., whether a state law complied with the federal standards would turn into a clinical argument about medical and nursing practices).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PHONE: (202) 690-5824
FAX: (202) 690-8344

TO: Jennifer Klein

FROM: Brian Biles Bob St. Peter

FAX NUMBER _____

DATE 6-7-94

TOTAL NO. OF PAGES (INCLUDING COVER) 4

Talk to → Nurses → 90%

4-5308 Rm 527
4-7679

Nurse anesth, nurse midwives, nurse practitioners,
→ [Nurse
PAs

→ Does not allow indep. practice

→ Fed determination of what a restrictive practice is

DRAFT

L&HRBILL.V1

PREEMPTION OF STATE PRACTICE LAWS

If the Committee's goal is to:

Clarify Section 1161 to specify:

1. Which types of practitioners are covered, and

2. How a determination would be made that a State is restricting practice

Then the Committee could:

1. Specify that the provision would apply to advanced practice nurses. An advanced practice nurse would be a nurse who:

   A. Has been awarded a master's degree or post-master's certificate following completion of an accredited training program preparing individuals in advanced practice nursing specialties and

   B. Is authorized by the state to practice as an advanced practice nurse

2. Provide for the Secretary to publish a notice specifying minimum standards for a state practice act for advanced practice nurses

   A. The notice would include a description of state policies that are deemed to restrict the practice of advanced practice nurses beyond what is justified by the education and training of such professionals

   B. A preliminary notice would be published for public comment by July 1, 1996

   C. A final notice which takes into consideration public comments received would be published by December 31, 1996

DRAFT

3. Specify that, effective two years after publication of the final notice, no State would establish or enforce any law or regulation of the type specified in the final notice of the Secretary as restricting the practice of an advanced nurse practitioner beyond what is justified by the education and training of such professionals

   A. Subsequent to the effective date of the final notice, any individual or other party who is adversely affected by State law or regulation unreasonably restricting the scope of practice of an advanced practice nurse may bring suit to carry out this action

4. The Secretary would, within 6 months after the date of the enactment of this subsection, develop a digest of State laws, regulations, and practices pertaining to the licensure and scope of practice of advanced practice nurses

   A. The digest would be updated at least annually

   B. Following publication of the Secretary's notice of policies, the digest would indicate which State laws, regulations and practices appear to unduly restrict the scope of practice for advanced practice nurses

   C. The Secretary would also ensure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section

DRAFT

DRAFT

L&HRTALK

JUN 6 1994

TALKING POINTS

OVERRIDE OF STATE PRACTICE ACT LAWS

- Rather than protecting the public, State practice acts have become an economic battleground between professions
- State laws which prevent advanced practice nurses from providing all the patient care services they are trained to provide:
  - artificially restrict access to services and patient choice
  - prevent competition and drive up costs
  - are granting a form of legal monopoly
- Advanced practice nurses receive a general education that is quite similar regardless of where they receive their education
  - APNs are already required to take a national examination
  - A national infrastructure is already set up for certification as well.
    * While only some states currently use the national certification process, all could if they chose to do so
    * Certification is administered by the American Nurses Association and other relevant specialty organizations
- Thus, there is little reason to have separate state laws for advanced practice nurses (APNs)

As Americans, we have the highest quality health care, the most talented and dedicated health professionals, and the most advanced research institutions in the world. We must preserve what is good about our health care system.

The problem is that too many Americans are unable to get the health coverage that they need. Some are denied insurance because of a preexisting condition; others simply can not afford it. And, as a result, too many physicians and hospitals are forced to absorb the costs of providing emergency care to uninsured individuals who wait until their illnesses are serious and costly before seeking care.

The Clinton plan preserves what is right with our health care system and fixes what is wrong.

EXPANDING CHOICE

Today, choice <u>of</u> doctors and choice <u>for</u> doctors is steadily decreasing. As costs continue to rise, employers limit their employees' choices of health plans and drop traditional insurance plans that allow individuals to see any doctor they choose. One in five American families say that they have involuntarily changed their doctor in the last five years (Employee Benefit Research Institute, 1993). In 1988, 89% of employers offered traditional insurance plans where individuals could choose any doctor. By 1993, only 65% of employers offered such plans (KPMG Peat Marwick, 1993). As a result, more and more doctors have joined health maintenance organizations in order to keep their patients and attract new patients.

The Clinton plan expands choices for both doctors and patients. Families, not employers, will choose among all of the health plans available in an area. All Americans will be given the opportunity to join a fee-for-service plan that allows them to see any doctor they choose. Even those Americans enrolled in health maintenance organizations may purchase a point-of-service option that permits them to see any doctor outside of the HMO. As a result, under the President's proposal, every American will be able to choose their doctor and health plan. Doctors and nurses will choose what health plans they want to join and may join several plans.

PRESERVING QUALITY

The President's plan builds on the high quality of health care currently provided in this country. Our doctors provide the highest quality health care in the world. However, too often,

insurers tell doctors what services they can provide and how much they will be paid. Under the President's plan, information will be made available about consumer satisfaction and health outcomes in health plans, including any utilization review procedures used by a plan. With increased choice and a real opportunity for consumers to evaluate plans, health plans will leave to doctors and their patients the decisions about what care is medically necessary or appropriate in a particular situation.

SIMPLIFYING OUR SYSTEM

According to the American Medical Association, the average physician spends 40 hours a month on billing and paperwork. In the last decade alone, the number of hospital administrators grew 16 times as fast as the number of doctors (The National Data Book, Statistical Abstract of the United States, 1993).

The President's proposal will provide a uniform, comprehensive benefit package with standard cost sharing rules. A single, standard reimbursement form and uniform reporting requirements will replace hundreds of existing claims forms. Doctors and nurses will be freed from insurance company red tape to spend more time on patients than on paperwork.

Jennifer,

Attached is the health professions override incoming and two versions of a draft response. The difference in the versions is just the ordering of the paragraphs. See what you think.

Sharman

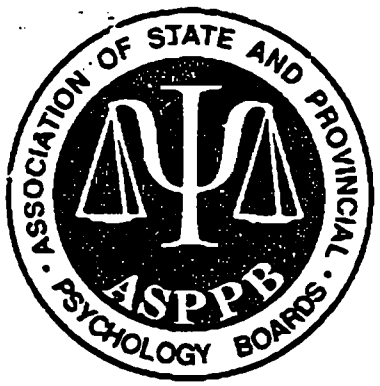
OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▶ 7

To Jennifer Klein	From Sharman
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

279160 ML



Formerly AMERICAN ASSOCIATION OF STATE PSYCHOLOGY BOARDS

April 7, 1994

Senator Howell Heflin
728 Hart Senate Building
Washington, D.C. 20510

OFFICE OF SENATOR HEFLIN
94 APR 12 PM 1:37

Re: Health Security Act

Dear Senator Heflin:

Recently this Association became aware that the Clinton administration's current version of the Health Security Act contains a provision that could allow federal preemption of state practice acts. Section 1161 reads:

> "No state may through licensure or otherwise restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals."

On behalf of all the state and territorial psychology licensing boards, we urge you to oppose the passage of this Act if such language is included in a future or final version. There are several reasons for our opposition.

First, the language is so vague that it will be difficult to determine which "health professionals" will be included and whose scope of practice may not be "restricted." Clearly, psychologists would be included, but would the prohibition affect unlicensed (and in many cases unlicensable) "psychotherapists", or even "paraprofessionals". What do the words "justified by the skills and training of such professionals" mean? After all, the Health Security Act does not contain standards or mechanisms for interpretation. Does this Act contemplate that a federal agency will determine the classes of protected health professionals and the appropriate scope of practice of each? If so this could result in a giant step backward in terms of the protection of the public.

Additionally, no enforcement mechanisms are specified in the Act. Will passage of an Act with such a provision create a private right of action by which unlicensed individuals or groups of individuals might sue a licensing board for restricting or prohibiting certain practices?

400 S. Union Street, Suite 295 • P.O. Box 4389 • Montgomery, AL 36103 • (205) 832-4580 • FAX: (205) 269-6379

Clearly the ambiguity of this provision is so obvious that any version of the act that includes such language should be opposed and we strongly urge you to do so.

Sincerely,

Paul G. Schauble

Paul G. Schauble, Ph.D.
President, ASPPB

/kt

VERSION 1

Honorable Howell Heflin
728 Hart Senate Building
Washington, D.C. 20510

Dear Senator Heflin:

Thank you for sharing with us the letter from Dr. Paul G. Schauble, President of the Association of State and Provincial Psychology Boards, expressing concern about the provision in the Administration's Health Security Act (HSA) which would override unduly restrictive state practice laws. I have been asked to answer your letter because my office is coordinating health care reform within the Department of Health and Human Services.

As you know, the benefit package of the Health Security Act specifies a broad range of medically necessary or appropriate services including inpatient and outpatient hospital care, clinical preventive services, mental illness and substance abuse services, outpatient rehabilitation services, home health care, extended care, and services of health professionals. The Act does not specify the range of professionals who can provide covered services. These decisions are left to States through licensure and health plans through negotiations with providers. However, since the intent of the Act is to encourage efficient delivery of care through private health insurance, it is our hope that as we change incentives for insurance plans to deliver care more effectively, plans will be encouraged to select those services and professionals that efficiently promote health. We believe that this flexibility, supported by quality performance reports that tell consumers and providers about health outcomes and consumer satisfaction, will broaden opportunities for a broad range of health professionals in a reformed health care system.

Already health care is moving towards more competition. Consequently, it is important that laws regulating health professions' scope of practice be based on actual competencies and training rather than pressures of competing professional groups. The override provision is a limited approach for addressing inappropriate restrictions on the scope of practice of health professionals that are not based on actual clinical competencies ("skills and training") of those professionals. Indeed, the Health Security Act override provision, referenced by Dr. Schauble, is meant to address some of the problems that have been experienced by professional groups like psychologists.

I would like to emphasize that it is not the intent of the Health Security Act to vest scope of practice authority in the Federal Government. Under the Act, States would continue to maintain their licensure and certification role.

You can also assure Dr. Schauble that it is not the intent of the HSA to create a private right of action by which unlicensed individuals might sue a licensing board, nor does it otherwise empower unlicensed groups. The HSA defines "health professional" to include only those professionals licensed by a state. Thus, the provisions about which Dr. Schauble is concerned apply only to licensed professionals. Professional psychologists should not be concerned about paraprofessionals who have neither the skills, competence or training to provide the services in the comprehensive benefit package. Under the Act, each state, not the federal government, determines the classes of protected health professionals.

The Clinton Administration is committed to the delivery of quality, cost-effective health care. As the bill is debated in Congress, we intend to work with the Congress on how best to achieve this goal. Thank you for sharing Dr. Schauble's concern with us, and I hope that this information regarding health professional services is helpful in responding to him.

Sincerely,

Judith Feder, Ph.D.
Principal Deputy Assistant Secretary
for Planning and Evaluation

VERSION 2

Honorable Howell Heflin
728 Hart Senate Building
Washington, D.C. 20510

Dear Senator Heflin:

Thank you for sharing with us the letter from Dr. Paul G. Schauble, President of the Association of State and Provincial Psychology Boards, expressing concern about the provision in the Administration's Health Security Act (HSA) which would override unduly restrictive state practice laws. I have been asked to answer your letter because my office is coordinating health care reform within the Department of Health and Human Services.

You can assure Dr. Schauble that it is not the intent of the HSA to create a private right of action by which unlicensed individuals might sue a licensing board, nor does it otherwise empower unlicensed groups. The HSA defines "health professional" to include only those professionals licensed by a state. Thus, the provisions about which Dr. Schauble is concerned apply only to licensed professionals. Professional psychologists should not be concerned about paraprofessionals who have neither the skills, competence or training to provide the services in the comprehensive benefit package. Under the Act, each state, not the federal government, determines the classes of protected health professionals. I would like to emphasize that it is not the intent of the Health Security Act to vest scope of practice authority in the Federal Government. Under the Act, States would continue to maintain their licensure and certification role.

As you know, the benefit package of the Health Security Act specifies a broad range of medically necessary or appropriate services including inpatient and outpatient hospital care, clinical preventive services, mental illness and substance abuse services, outpatient rehabilitation services, home health care, extended care, and services of health professionals. The Act does not specify the range of professionals who can provide covered services. These decisions are left to States through licensure and health plans through negotiations with providers. However, since the intent of the Act is to encourage efficient delivery of care through private health insurance, it is our hope that as we change incentives for insurance plans to deliver care more effectively, plans will be encouraged to select those services and professionals that efficiently promote health. We believe that this flexibility, supported by quality performance reports that tell consumers and providers about health outcomes and consumer satisfaction, will broaden opportunities for a broad range of health professionals in a reformed health care system.

Already health care is moving towards more competition. Consequently, it is important that laws regulating health

professions' scope of practice be based on actual competencies and training rather than pressures of competing professional groups. The override provision is a limited approach for addressing inappropriate restrictions on the scope of practice of health professionals that are not based on actual clinical competencies ("skills and training") of those professionals. Indeed, the Health Security Act override provision, referenced by Dr. Schauble, is meant to address some of the problems that have been experienced by professional groups like psychologists.

The Clinton Administration is committed to the delivery of quality, cost-effective health care. As the bill is debated in Congress, we intend to work with the Congress on how best to achieve this goal. Thank you for sharing Dr. Schauble's concern with us, and I hope that this information regarding health professional services is helpful in responding to him.

Sincerely,

Judith Feder, Ph.D.
Principal Deputy Assistant Secretary
for Planning and Evaluation

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Sharman Stephens

To: Jennifer Klein

Phone: (202) 690- _____
(202) 690-6870
FAX: (202) 401-7321

Phone: _____

Fax: _____

Number of Pages (Including Cover): 7

Comments: Pat De Leon response

NOTE TO Jen Klein

From: Sharman Stephens
Lisa Rovin

SUBJECT: Psychologists Admitting to Hospitals

Karen Jackson has been doing some phone calling about private insurers practices in covering psychologists services' as independent practitioners admitting to hospitals. In the case of California we have heard two different accounts. From one source we heard reimbursement is not a problem. In another conversation we heard that reimbursement did vary, with some insurers requiring that inpatient care involve medication therapy, and hence the involvement of a physician. This later situation is similar to what we heard from Florida.

In Wisconsin it appears that the insurers recognize the psychologists as the admitting practitioner and pay accordingly. Sometimes where a patient also sees a physician there are some rules about not paying the physician and psychologist on the same day. Maryland also recently changed its hospital practice law to permit each hospital the option of granting admitting priveleges to psychologists. The person we talked to indicated that progress is slow with only one hospital in the Baltimore-Washington area having changed its by-laws to date. The insurers in that situation do appear to be paying for psychologists admitting patients.

Attached is a proposed draft response to Pat De Leon on the this subject as well as the psych rehab issue. I used the Medicare home health respiratory therapy letter as a model, see what you think.

cc. Bob Van Hoek

5/4/94

DRAFT ~~4/28/94~~

Patrick H. De Leon
Administrative Assistant
Senator Daniel K. Inouye
Suite 722, Hart Senate Office Building
Washington, D.C. 20510-1102

Dear Mr. De Leon:

Thank you for sharing with me the memorandum from Russ Newman (American Psychological Association) regarding provisions of the Health Security Act's coverage for services provided by psychologists admitting patients to hospitals and coverage for mental illness related outpatient rehabilitation services provided by psychologists.

The benefit package of the Health Security Act specifies a broad range of medically necessary or appropriate services including inpatient and outpatient hospital care, clinical preventive services, mental illness and substance abuse services, outpatient rehabilitation services, home health care, extended care, and services of health professionals. The Act does not identify specific providers of services.

The Act defines health professional services to include those services that are lawfully provided by a physician, or those services which could be performed by a physician and which are provided by another person who is legally authorized to provide those services in the state. It is expected that competition among health plans will create new incentives for effective use of other providers. Plans will be free to use any mix of providers to meet the needs of their enrollees.

In drafting the legislation knowledge and expertise gained from existing Federal health programs like Medicare was used. The Medicare statute also served as a source for some legislative definitions. Nevertheless, I recognize the concern about the Health Security Act's connection to Medicare policy which requires that every Medicare hospital patient be under the care of a physician. The Clinton Administration is committed to the delivery of quality, cost-effective health care. As the bill is debated in Congress, we intend to work with the Congress to identify the best benefit package that can be guaranteed to all Americans.

With regard to coverage of rehabilitation services related to a mental illness and substance abuse, the Health Security Act includes these services under the mental illness and substance abuse portion of the benefit package. Psychiatric rehabilitation is one of the services listed under intensive nonresidential treatment services. One of the listed treatment purposes of intensive nonresidential services is to restore the functioning

of an individual. The mental illness and substance abuse benefit also includes outpatient services including screening and assessment, diagnosis, medical management, substance abuse counseling and relapse prevention, crisis services, somatic treatment services, psychotherapy, case management, and collateral services.

I hope that this information is helpful. I look forward to continuing to work with you on health care reform.

Sincerely,

Judith Feder

DANIEL K. INOUYE
HAWAII

APPROPRIATIONS
Chairman, Subcommittee on Defense

COMMERCE, SCIENCE AND TRANSPORTATION
Chairman, Subcommittee on Communications

Chairman, COMMITTEE ON INDIAN AFFAIRS

Chairman, DEMOCRATIC STEERING COMMITTEE

Member, COMMITTEE ON RULES AND ADMINISTRATION

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HILO, HI 96720
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FAX (808) 961-5163

March 7, 1994

file - Psychologists
Mental Health

Ms. Judy Feder
Office of the Assistant Secretary
for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave., S.W., Rm. 415-F
Washington, D.C. 20201

Dear Ms. Feder:

Following up on our recent discussion, I have enclosed for your files a copy of a memorandum we recently requested from Dr. Russ Newman, of the American Psychological Association, indicating specifically where, in his judgment, the Administration's bill would inadvertently be of considerable "harm" to psychologists. Your continued assistance would be deeply appreciated.

We would also point out that the various health manpower training initiatives do not seem to allow psychology to apply.

Aloha,

P. H. D.

PATRICK H. DE LEON
Administrative Assistant

PHD:blw
Enclosure

cc: Dr. Russ Newman
Dr. Ellen Caringer

9403300011

AMERICAN PSYCHOLOGICAL ASSOCIATION

MEMORANDUM

To: Pat DeLeon, Ph.D., J.D.

From: Russ Newman, Ph.D., J.D.

Subject: Health Care Reform/Health Security Act

Date: February 17, 1994

As we discussed, there are at least two instances related to health care reform, in general, and the proposed Health Security Act, in particular, where psychologists appear inadvertently restricted or omitted. Ironically, in one instance certain Medicare restrictions on psychologists' practice are incorporated in the Health Security Act while in the other instance psychologists are authorized for certain practices under Medicare, but not so authorized by the proposed Health Security Act.

Medicare Conditions of Participation

Since the OBRA 1989 amendment to the Medicare program, psychologists have been authorized to perform services consistent with state law and to receive direct reimbursement in all settings. A number of states, including California and the District of Columbia (as well as nine other jurisdictions), permit psychologists to be appointed to the medical staff of hospitals, and allow psychologists to independently admit, diagnose, treat, and discharge patients with psychological problems. This practice is, of course, contingent upon a physician examining the patient upon admission and administering any drug regime or related medical care the patient may need. The Medicare Conditions of Participation for psychiatric hospitals, however, are being interpreted in a fashion that will not permit psychologists the full range of practice allowed by state law.

In particular, 42 CFR sec. 482.60 provides special conditions of participation for psychiatric hospitals, and incorporates the requirement of section 482.12(c)(4) that a doctor of medicine or osteopathy must be "responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization." This provision, among others, is intended to implement the statutory requirement of section 1861(e)(4) of the Social Security Act (42 U.S.C. Sec. 1395(e)(4)) that every Medicare patient be "under the care of" a physician. As a result,

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Practice Directorate

restrictions on psychologists' practice in hospitals have remained, although we continue our efforts to resolve these issues.

Unfortunately, the Health Security Act, Title I, Section III (c)(1), incorporates by reference the aforementioned Medicare provisions which have been restrictively interpreted against psychologists. The result, then, is likely to be restrictions on psychologists' ability to independently treat non-Medicare beneficiaries in hospitals. This would be true even in states which expressly authorize independent hospital practice, and in conflict with the Health Security Act's intent to support the ability of non-physician providers to practice to the full extent of their licensure.

Rehabilitation Services

While the above described restrictive Medicare provisions are incorporated into the proposed Health Security Act, the authorization of psychologists in Medicare to provide rehabilitation services is not expressly incorporated. Section 1123(a) of the Health Security Act describes coverage for outpatient rehabilitation services to include occupational therapy, physical therapy, and speech pathology services for the purpose of attaining or restoring speech.

As you know, we are concerned that the absence of explicit mention of psychological/neuropsychological services in this section may work to prevent psychologists from providing the very same services in a reformed health system that they have been providing for years under the Medicare program. Should this occur, it would most certainly have a damaging effect -- albeit unintentional -- on both patients and psychologists. This could be easily remedied by amending section 1123(a) by deleting the word "and" immediately preceding "(3)" and adding the following at the end of the subsection but before the period:

> "; and, (4) outpatient psychological and neuropsychological services for the purpose of restoring functional capacity or minimizing limitations to functional capacity associated with cognitive or psychological consequences or physical illness or injury."

If you have any additional questions concerning these issues please do not hesitate to contact me.

cc: Donna Daley

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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Date:

From: Lisa Rovin To: Jennifer Klein

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Number of Pages (Including Cover): 6

Comments:

TO: Jennifer Klein
Don Johnson
Sam Shaker
Gary Claxton
Bob Valdez
FROM: Rovin, van Hook
RE: Enrollment of Vulnerable Populations Under the Health Security Act (HSA)

Public hospitals are raising questions regarding enrollment of vulnerable populations into health plans.[1] They are concerned that their current clientele may "fall between the cracks" of the HSA enrollment process in ways which will increase the hospitals' costs. To address these concerns, we need to identify possible enrollment problems and determine how the HSA handles them.

Vulnerable populations are more likely than the general population to fail to enroll in a health plan during open enrollment, to enroll in one plan but seek care from providers not affiliated with that plan, to forget that they have enrolled, to not know their names when they seek care, etc. Under the HSA, what happens when an unenrolled person seeks care? How is the provider compensated? What happens if the person seeking care is enrolled in a plan with which the provider is not affiliated? What happens if the person cannot be identified, or his enrollment status cannot be verified?

A. Relevant HSA Provisions

Each regional alliance must establish a point-of-service enrollment mechanism, for instances in which an eligible person seeks services from a provider but does not present evidence of enrollment in a plan. The following procedures apply.

1. Initial Contact With the System

When services are rendered to a person who presents no evidence of enrollment (and the provider has no evidence of enrollment), the provider is required to notify the regional alliance, and forward information regarding the identity of the person. The provider may also submit a claim for payment. The alliance determines if the person is eligible, and if the person is already enrolled in a health plan.

- If the person is eligible and already enrolled, the alliance forwards the provider's claim to the plan and notifies the provider. The plan must pay the provider. (See § B.2., below, regarding the plan's payment obligation.)

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1. The full range of public hospital issues, including replacement of DSH payments and the adequacy of the vulnerable populations payment pool, are not addressed in this memo.

- If the person is eligible but not enrolled in a plan, the point of service enrollment mechanism (described in §A.2., below) applies.

- The National Board is to promulgate regulations describing the responsibility of regional alliances for persons who the alliances are "unable to identify as eligible individuals."

Regardless of eligibility or enrollment status, the regional alliance has no obligation to pay the providers.

2. Point-of-Service Enrollment

An alliance's point of service enrollment mechanism must meet the following requirements:

- The alliance must provide the unenrolled person with materials describing the plans offered through the alliance not later than 10 days after the date an alliance is notified of the receipt of services by an unenrolled eligible person.

- The unenrolled person has 30 days to enroll.

- If the person has not enrolled after 30 days, the alliance must enroll the person in a health plan, selected at random.

Among plans at average? Lower cost?

- The alliance forwards the provider's claim for payment to the health plan into which the person is enrolled. That health plan must reimburse the provider, under the regional alliance fee schedule.

B. Issues

Vulnerable populations may present enrollment issues not fully covered by the above described enrollment process. Some of these scenarios are described below. Where the HSA does not specify a solution, what is envisioned? Is the solution a matter for federal regulation? for determination by the State? for determination by the regional alliance?

1. Problematic Enrollment Scenarios

The Homeless: After the unenrolled person seeks care at the public hospital and the hospital has provided the information to the regional alliance, the alliance cannot locate the person and thus does not meet the 10 day deadline.

The Mentally Unstable: Not all persons who today obtain care from a public hospital are able to identify themselves accurately or consistently. Under the HSA, such a person may enroll in a plan (either during open enrollment or

through the point of service process) under one name, but then seek care under another. The person may have lost his card or may not recall enrolling.

The Mentally Challenged: Not all persons who today obtain care from public hospitals are able to understand the concept of enrollment or of participating providers. Under the HSA's random enrollment requirement, such a person may be enrolled into a managed care plan. Yet, this person may continually seek care from a provider not affiliated with the plan into which he was enrolled.

Persons Who Do Not Speak English, Scenario 1: The concept of participating provider may not be appropriately explained in a language they understand. They may continue to seek care from the public hospital even after they have been randomly enrolled in a plan in which the hospital does not participate.

Persons Who Do Not Speak English, Scenario 2: A person who does not speak english may continue to seek care from the nonparticipating public hospital, even if she understands that she has been randomly enrolled in a different plan, because: (1) the plan does not have an appropriate translator, while the public hospital does; (2) the public hospital physicians/nurses understand cultural factors related to health care, while the plan providers do not.

Persons With Specialized Care Needs: Persons may be randomly assigned to a plan which cannot address their specialized needs as well as the public hospital, and may therefore continue to seek care from the public hospital.

2. Problematic Payment Scenarios

Payment Amount. The amount of the plan's payment obligation is unclear. Section 1323(b)(3)(C) requires payment "using" the alliance fee schedule, but at the same time requires payment "to the same extent as if the individual had been enrolled under the plan at the time of provision of the services." It is unclear what is to be paid if, for example, the person is enrolled in a closed-panel HMO. If the first clause was intended to apply when the person is not already enrolled and the second when the person was already enrolled, this should be clarified. If this is the intended reading, at least two additional problematic issues regarding vulnerable populations arise:

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- If a person is already enrolled in a closed-panel HMO when care from the public hospital is sought, and the public hospital is not in the plan's participating provider panel, the hospital may not be paid for services rendered.

No, must be reimbursed acc. to fee schedule. But then isn't everyone enrolled in POS. Maybe distinction is emergency v. nonem. services

- If a person is in a POS option of an HMO or a PPO-type plan when care is sought from the public hospital, and the public hospital is not in the plan's participating provider panel, the public hospital's exposure for copayment bad debt may be increased.

Payment Delay. Even if the point of service enrollment works perfectly, the provider will not be paid for at least 60 days (10 days for the alliance to notify the individual, another 30 for the person to choose a plan, plus time for the claim to be sent to the new plan, processed, and paid.

Payment Differentials. Plans will have rules requiring a larger enrollee contribution for use of out-of-network providers. How do such rules apply to a person who is unaware of them or unable to understand them?

3. Additional Issues For Discussion

Risks of Random Enrollment. The HSA point of service process makes it possible for a person to be randomly enrolled in a plan without her knowledge (i.e., the alliance cannot locate her). If so, she may be enrolled into a plan that does not include her current providers (in this case, the public hospital), and she may continue to seek care from the public hospital. Risk #1: If she is enrolled into a closed-panel managed care plan, the care she receives at the public hospital will not be covered. Risk #2: If she is enrolled into a point-of-service option or combination cost sharing plan, she will be liable for out-of-network fees she did not know she was incurring.

Risks of Non-Random Enrollment. One way to reduce Risk #1, above, is to exclude from the random enrollment process all plans with no out-of-network option (this would exclude only closed panel HMOs). Persons could be randomly enrolled only into: a managed care point-of-service option, a PPO-type plan, or a fee-for-service plan. One way to reduce Risks #1 and 2 is to include in the random enrollment process only those plans affiliated with the provider from whom the unenrolled person sought care (i.e., only plans where that provider is "in-network"). However, both of these "fixes" creates significant adverse selection.

C. Next Steps

We will schedule a meeting on these issues. Meanwhile, please call Bob or Lisa with your thoughts on these issues.

As we address these matters, there is a set of related issues we should begin to think about. The HSA addresses some of the costs of vulnerable populations through risk adjustment and authority for alliances to provide financial incentives to health

plans. Public hospitals raise the concern that these provisions compensate health plans, not providers; health plans are under no obligation to pass along such monies to the providers actually treating vulnerable populations. Vulnerable populations create these and other plan-provider tensions (i.e., nonpayment of co-payments, non-routine waiver of copayments). Are these matters best left to provider-plan negotiations? Is there a role for federal regulation, or are these matters best left to states or alliances?