

**Physician Supervision and Insurance
Reimbursement: Policy Implications for NP
Practice In NC**
NCIOM Health Professional Workforce Meeting

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Objectives

- Describe the Evolution of NP profession
- Synthesize the National NP Regulatory Environment with Emphasis on Southern States
- Compare the policy impact of physician supervision and insurance reimbursement policies on NP practice and consumer access to care
- Recommend policy suggestions to ensure full utilization of NPs as primary care providers in NC

Inception of NP Profession

- 1965: 1st NP program piloted University of Colorado
 - Dr's Henry Silver and Dr. Loretta Ford
 - Need for accessible health care in underserved, rural areas.
 - Physician shortages and the NPs filled the gap.
 - Used a nursing model to deliver health promotion/disease prevention to vulnerable populations.



Historical Overview of NP Practice in NC

- First NP program established @ UNC-CH
 - late 1960's with first cohort graduating in 1970.
 - Viewed as National Model in Nursing Regulation & NP practice
 - NC with a history of regulatory excellence
 - First NPA 1903
- Political compromises made to establish initial NP regulatory model.
 - Inclusion of physician supervision and medical model into advanced nursing practice model.
 - Paved the way for subsequent national NP regulatory trends.



NCSBN APRN Model Regulation

- Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee
- The APRN Model of Regulation described will be the model of the future.
- APRNs (CNM, CRNA, CNS, CNP)
- LACE



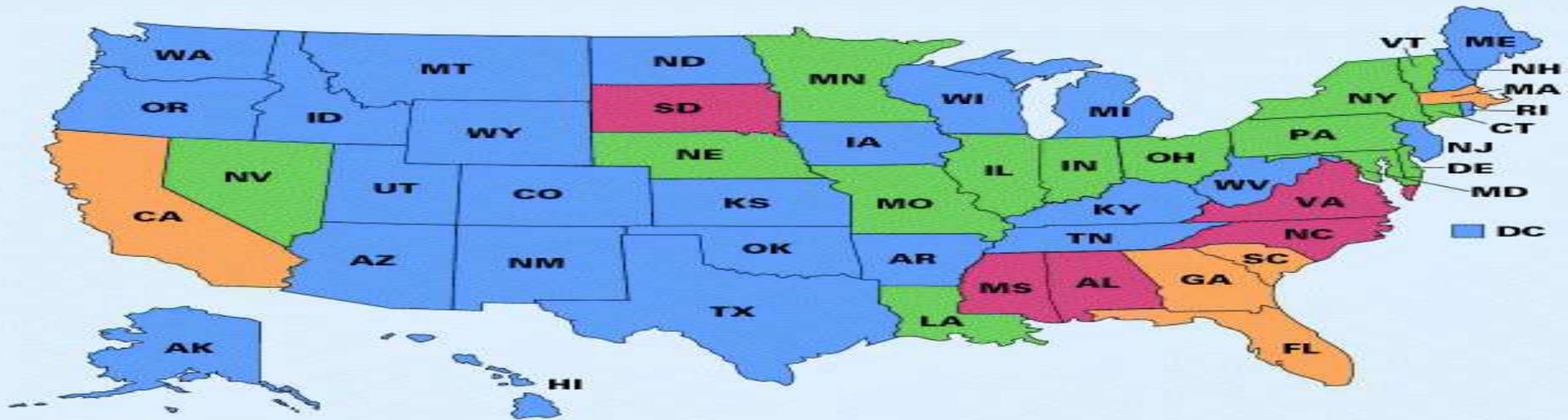
Consensus Model Goals

- Would continue to promote quality APRN education and practice
- Develop standardized, national APRN regulation, including education, accreditation, certification, and licensure;
- Establish a set of standards that protect the public, improve mobility, and improve access
- to safe, quality APRN care; and
 - Endorsed by APRN groups, NCSBN, IOM



NP Practice Rules & Regulations

- Joint Regulation by BON & BOM through Joint Subcommittee
 - **Joint regulatory model has become increasingly cumbersome and divisive**
 - **NC one of five states remaining with joint regulatory model**

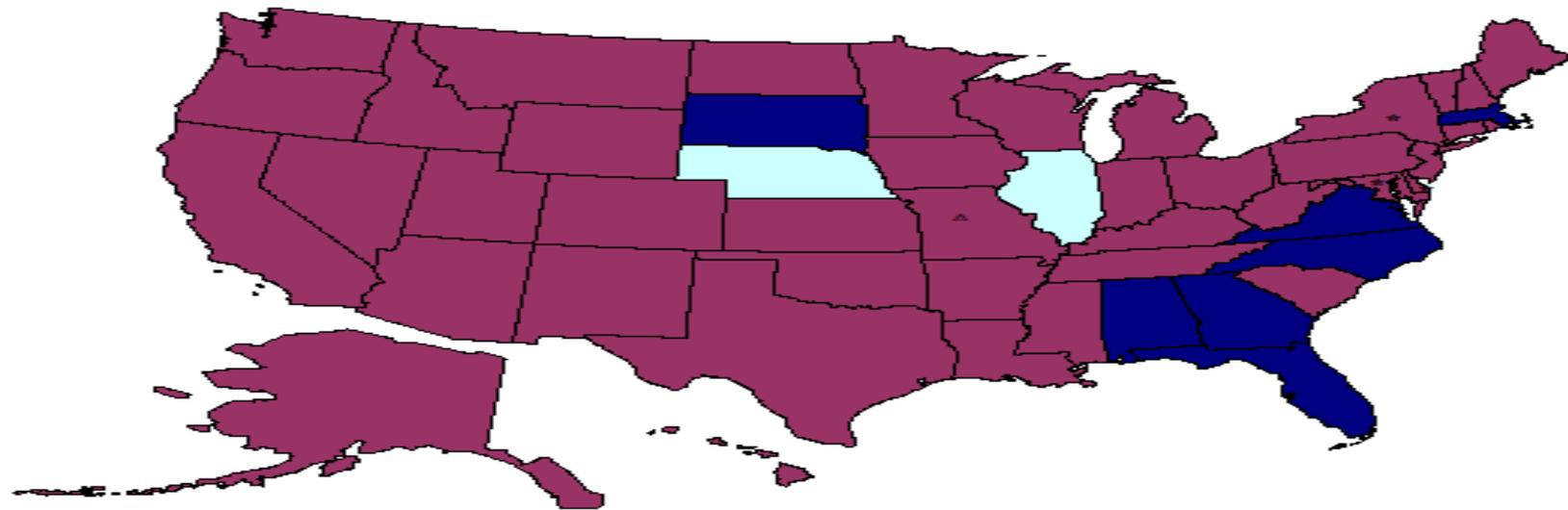


- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, with no statutory or regulatory requirements for physician collaboration, direction, or supervision: AK, AR, AZ, CO, DC, HI, IA, ID, KS, KY, ME, MI, MT, ND, NH, NJ, NM, OK, OR, RI, TN, TX, UT, WA, WI, WV, WY
- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician collaboration: CT, DE, IL, IN, LA, MD, MN, MO, NE[†], NV, NY, OH, PA, VT
- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician supervision: CA, FL, GA, MA, SC
- States with nurse practitioner** title protection, but the scope of practice is authorized by the board of nursing and the board of medicine: AL, MS, NC, SD, VA

[Washington, D.C., is included as a state in this table.]

- * This table provides a state-by-state summary of the degree of independence for all aspects of NP scope of practice, including diagnosing and treating (except prescribing). See Table: "Summary of APN Legislation: Prescriptive Authority" for a state-by-state analysis of NP prescriptive authority.
- ** This information may apply to other APNs (clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists). See "Summary of Advanced Practice Nurse Population" for details.
- † State with APRN Board.

NURSE PRACTITIONER REGULATORY AUTHORITY



- States with Nurse Practitioner Regulations Controlled by Board of Nursing
- States with Nurse Practitioner Regulations Controlled by Board of Nursing and Board of Medicine
- States with Separate Advanced Practice Board
- △ Prescription Only Under Joint Authority of Board of Nursing and Board of Medicine
- ★ State Education Department

Source: State Nurse Practice Acts
©American Academy of Nurse Practitioners, 2008

The American Academy of Nurse Practitioners is the largest full service Nurse Practitioner organization representing the 130,000 Nurse Practitioners in all Specialties

Politics is local—Southern States

- The Southern States
 - Joint Reg (NC, SC, VA)
 - BON w Physician Supervision (FL, SC, TN)
- Uniform scope of practice for nursing
- ***WIDE variation in NP/APRN regulation/scope of practice.***
- Each of the southern states has some degree of statutorily required physician involvement in NP practice.
 - Collaborative Practice Agreement
 - On-site physician supervision

Variance In Physician Supervision Requirements

- No correlation with NP performance on safety or quality.
- No data to suggest that physician supervision leads to safer, better care
- Nurses tend to move from more restrictive to less restrictive states.
- States with more stringent requirements for physician supervision are less likely to credential NPs as PCPs.



Physician supervision

- Useful in inception of NP profession
- NPs accountable in law & regulation for our own practice.
- Numerous studies document the safety and efficacy of NP practice.
 - 1986 Office of Technology Assessment: ROL
 - 2000 Mundinger: RCT 1,316 pt. NP or Physician
 - 2002 Hansen-Turton—The Nurse Managed Health Center Safety Net: A Policy Solution for Reducing Health Disparities
 - 2004 Lenz: F/U Mundinger Study—Same Results
 - 2010 IOM: Future of Nursing: Leading Change, Advancing Health

Little correlation of physician supervision and NP outcomes

NP skills/outcomes are **NOT** the result of:

- Supervision
- Delegation
- Collaboration

NP Skills/outcomes **ARE** the result of:

- Educational preparation acquired through *at least* two nursing degrees
- Supervised APRN clinical education
- RN/APRN Licensure
- National Certification
- Maintained Competence through CE/training.

Supervision: Legal but unnecessary

- Continued requirement of MD supervision or CPAs has become an example of regulation being used for proprietary interests and economic defensiveness rather than consumer interests.
 - *Mullinix 2010*
 - *Ritter, A. and Hansen-Turton, T. (2008)*



Real Examples

- NP owned practices in western & Central NC threatened when supervising physician lost his license
 - 2000 clients with threats to their access to their choice of PCPs.
 - loss of employment by two NP owners
 - Potential loss of employment by clinic staff



Impact of Physician Supervision

- Fee for physician supervision unnecessarily increases healthcare costs
- Limits where NPs can serve
- Confounds NP productivity, billing, outcomes and accountability when NP services being billed and credited to physician
- ***Increases the likelihood of restrictive managed care contracting policies regarding NPs***



NC NP Reimbursement Realities

- NPs may be listed on the provider panels *if requested by their employing physician.*
- 1993 Third Party Reimbursement legislation
- A 2001 Managed Care Patient's Bill of Rights

Reimbursement Policies Threaten Healthcare Reform

- A 2008 study conducted by National Nursing Centers Consortium (NNCC) has found that nearly half (48%) of all major managed-care organizations in the United States do not credential or contract with nurse practitioners as primary care providers.

Billing Commercial Indemnity Insurers for NP Services

- **Variable Policies**
 - Payment at the same rate as physicians without requirement for admission to a provider panel,
 - Payment at a reduced rate,
 - Payment for NP-provided services when billed under a physician employer's name, and
 - Denial of payment for services provided by NPs.

Commercial MCOs' Coverage of NP Services

- Commercial MCO policies on empanelment of NPs vary, and include:
 - Admitting NPs to provider panels,
 - Declining to admit NPs to panels but allowing NPs to provide services for patients on a physician's panel, and
 - Declining to admit NPs to provider panels and permitting only those on provider panels to see patients.



Real NP Examples

- BCBS billing specialist rates fro PNP working in primary care setting.
- BCBS refusing to contract with NP owned practice.
- NP practice approved by BCBS; when supervising physician left & new supervising physician hired for NP practice, *BCBS would not renew contract with same NP/practice.*
 - *Viability of NP practice tied to inconsistent reimbursement policies tying NP to physician practice and limiting consumer choice in PCP*



CMS/Medicare

Medicare

- Balanced Budget Act of 1997 requires NPI
- NPs identified as PCPs
- “Incident To ”Billing
 - Limited to office setting
 - Physician must be on site
 - Cannot be a new patient or an old patient with a new problem
 - 85% physician rate

Medicaid

- Administered by the state
- Variable Rules
- **Medicaid Fee-for-Service**
 - 100% physician rate
- **Medicaid Managed Care Plans**
 - Reimburse only those providers admitted to the plan's provider panel.



Medicare

- Home Health/Hospice
 - NP can continue care but cannot order/authorize hospice or home health
 - Must still be signed by physician

Reimbursement Challenges of Private Payers

- Will not credential/contract with APRNs
- Will contract with APRNs, but only if they are employed with a physician
- Payer supervisory requirements are more strict than state requirements
- Non-equitable reimbursement
 - Patient co-pay for an APRN visit is excessive (ex: charging specialist co-pay for seeing a primary care pediatric nurse practitioner).

Policy Implications Physician Supervision

- NPs have a 46 year track record of safe, cost-effective, accountable primary healthcare with outcomes at least as effective as physicians.
- ACA will generate a tidal wave of newly insured seeking access to PC services.
- NPs must be recognized as leaders in healthcare reform and access to care
- Restrictive state regulation requiring physician supervision of NP practice unnecessarily limits NP practice and consumer access to proven PCPs with no proven improvement in healthcare outcomes and obscures NP care.



Reimbursement Policy Implications

- NPs deliver cost effective, safe, care within their SOP
- Variability in reimbursement policies create an unsustainable payment system for NPs
- Reimbursement policies requiring physician involvement in NP care increases costs and limits consumer choice
- NPs must be recognized as PCPs
- Included as full partners in
 - Medical Homes
 - Insurance Exchanges
 - ACO's



Policy Recommendations

- Support efforts that increase patient access to the full primary care provider workforce and allow patient choice in provider selection
- Re-engineer reimbursement systems to reflect the true costs of care in all practice settings for sustainable reimbursement
- Promote reimbursement based on services provided
- Track provider-specific outcomes for accountability in care
- Include NP led practices and NPs as full partners in Medical Homes, ACOs, insurance exchanges and other developing innovative models of care
- Remove outdated legislative and regulatory barriers that impede the utilization of NPs



Questions?

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