MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
50TH LEGISLATIVE SESSION
HOUSE OF REPRESENTATIVES

The meeting of the Human Services and Aging Committee was called to order by Chairman R. Budd Gould at 1:00 p.m. on Thursday, March 5, 1987 in Room 312-D of the State Capitol.

ROLL CALL: All members were present with the exception of Rep. Bob Gilbert, and Rep. Dick Corne' who were excused.

CONSIDERATION OF HOUSE BILL NO. 105:

Sen. Matt Himsel, District 3 Kalispell and sponsor of the bill, discussed the bill that would provide for audits of the Montana Medical Legal Panel by or at the discretion of the Legislative Auditor. He explained the panel as being established for the purpose of reviewing malpractice claims. This panel is attached to the Supreme Court for administrative purposes. A director is appointed by the executive director of the Montana Medical Association with approval of the chief justice. The funding is provided by a trust with no money reverting to the general fund. The fund is open to audit by the Legislative Auditor and is created by an annual surcharge levied on all health care providers. This legislation proposes that the audit determine the advocacy, sufficiency, and reasonableness of the charges for assessment. A copy of the audit must be presented to the Supreme Court and the cost of the audit paid by the panel. (Exhibit 1)

PROPONENTS:

JERRY LOENDORF, Montana Medical Association, supported the bill. He stated that the panel desires to be audited. He pointed out that the bill requires the auditor to determine reasonableness of the charges made to the providers so there would be no overcharges.

OPPONENTS: There were no opponents.

Sen. Himsel closed on the bill and said that there should be an audit so that the assessments made on services would be proper.

QUESTIONS FROM THE COMMITTEE: There were no questions.

CONSIDERATION OF SENATE BILL NO. 120:

Sen. Pat Regan, from Senate District 47 Billings, presented Senate Bill No. 120. She said that this bill grew out of

the interim study conducted by a health cost containment council appointed by the Governor. The insurers, or third-party payers were sometimes presented with bills for alcohol treatment and they felt that the person running the treatment was not qualified but could claim themselves to be a counselor. The bill provides that a third-party payer only has to pay when the treatment has been given by someone who has been approved by the Department of Institutions.

PROPONENTS:

MONA JAMISON, representing Rocky Mountain Treatment Center in Great Falls, spoke in support of the bill. She said that the treatment center was a facility that treated disorders related to alcohol and chemical addiction.

CHUCK BUTLER, from Blue Cross and Blue Shield of Montana, supported Senate Bill 120.

OPPONENTS: There were no opponents.

SEN. REGAN closed on Senate Bill 120.

QUESTIONS FROM THE COMMITTEE:

REP. CODY asked Sen. Regan about certifying by the department. Sen. Regan replied that certification was granted by the Department of Institutions and was spelled out in law.

There were no further questions.

CONSIDERATION OF SENATE BILL NO. 176:

SEN. DOROTHY ECK, District 40, discussed Senate Bill 176 which enables nurse specialists to file for third party payments from insurance companies. She pointed out the importance of nurse practitioners to rural areas in Montana.

PROPONENTS:

CATHY CANIPARILI, president of the Montana Nurse Practitioners state interest group from Livingston, presented testimony supporting direct reimbursement of nurse specialists by Medicaid and Health Services Corporation. She pointed out SB70 passed by the 1983 session omitted Medicaid. The intent of the bill was to provide the consumer with freedom of choice in selecting a health care provider to deliver services already covered in existing health policies and plans. She said that these specialists were directly responsible and accountable to the consumer for the quality of health services. SRS, Medicaid, Blue-Cross and Blue-Shield have denied payment to nurse specialists on the

basis that SB70 did not apply to their organization. Claims have been denied because Blue-Cross and Blue-Shield have identified themselves as a health services corporation rather than an insurance company. The state Insurance Commissioner has concurred with Blue-Cross Blue Shield that SB70 did not apply to health services corporations. An administrative rule change was requested by the Montana Nurse Practitioners state interest group and the Montana Nurses Association to the Department of SRS to provide direct reimbursement to nurse practitioners. This was denied by SRS and suggested the group take the matter before the legislature. She pointed out that the current forms of reimbursement are unfair and discriminatory. Nurse specialists can bill Blue-Cross Blue Shield and Medicaid for services they provide only through a physician or health care agencies. When reimbursement is made this way there is no credit given to the nurse specialist who is the actual provider of the services. Under they current reimbursement mechanisms for nurse specialists who is not employed by a physician or reimbursable health agency is forced to turn clients away from care or to provide care without compensation. This denies access to care by health care consumers, promotes unfair trade practices and creates barriers to recruiting nurse specialists to the state. She discussed a summary of significant findings of other studies about nurse specialists from other states. (Exhibit 2A-F)

BETH VEIGN, a family nurse practitioner from Great Falls, supports SB176. She cited an example for the reason the bill was necessary. She said she was currently providing care to two counties that surround Great Falls. She said that Montana was more than rural, that a new designation out of the Department of Health and Human Services called "frontier". She said that Judith Basin County has no physician services in the Well Child Programs. Choteau County, Fort Benton, has two physicians one of which does not accept Medicaid clients. Big Sandy, another town in Choteau county has one semi-retired physician. She said that the services she provided are aimed at the Well Child population. She performs routine physical exams, health assessments, counseling with parents. She pointed out that recently there had been ill children presented to the Well Child Clinic which she believes to be a reflection of the current farm economy. She said that when they see the physician he can bill and be reimbursed but when they see a nurse practitioner she is unable to bill yet is able to provide the service. (Exhibit 3)

BARBARA BOOHER, executive director of the Montana Nurses Association, presented written testimony from Alice Honrun (Exhibit 4). She summarized what the consumer said that

they are able to utilize the services and reduce fees and would like these services reimbursed.

MARGO CALDWELL, previous nurse practitioner from Lewistown summarized a letter from the Montana Senior Citizens Association (Exhibit 5). She pointed out health care accessibility, maintenance and cost containment that SB176 was supported by MSC.

TONYA STRATFORD, office manager for a Nurse Anethesis in Miles City, said that it took several years with attorney involvement to gain reimbursement with Blue-Cross Blue-Shield. She said they did not check the insurance company before they did surgery. When doing surgery an anesthesis is required. SRS came out with a management decision to not reimburse. The doctors had to tell their welfare patients to go to Billings. She pointed out that people on Medicaid could not be collected from because they could not pay their bills. She said the services are being provided and the provider should be paid.

PEGGY MUSSEHL, president of the Montana Nurses Association, testified in support of SB176. She discussed the intent of SB70 to provide for reimbursement to nurse specialists by all insurance companies and medicaid. She stated that because of loopholes in the law, reimbursement by health service corporations and medicaid had been withheld. (Exhibit 6)

CHUCK BUTLER, from Blue-Cross and Blue-Shield of Montana, pointed out that health service corporations did not fall under previous legislation. He said they have not paid for the services of nurse practitioners, however currently nurse anesthesis are paid. He supports the bill and recommends a do pass.

OPPONENTS:

LEE TICKELL, administrator of the economic assistance division of SRS, clarified the issues with regards to the Medicaid program. He said that specific language included in HB500 last session that prohibited the department from expanding the scope amount or duration of the Medicaid program. He clarified that in terms of the coverage that the federal regulation require as mandatory service nurse midwifes. It does not include within the federal regulations the other nurse practitioners, they are included as an optional service. Clearly if the intent of the legislature is to direct the department to cover nurse practitioners either as a mandatory or optional service that is what they would do.

Senator Eck closed on SB176. She said that the question that SRS raises is technical. This bill would give SRS direction. She pointed out that this would provide an opportunity for broader service at lesser cost.

QUESTIONS FROM THE COMMITTEE:

REP. SANDS questioned whether this would increase costs in SRS and if so how much. Lee Tickell replied that generally it may save money.

REP. PATTERSON asked Sen. Eck for definition of a nurse specialist. Sen. Eck replied that the definition was covered in the Board of Nursing laws and gives the authority to the board for new services in 8-32-304.

REP. KITTSELMAN questioned Mary Munger about the nurse specialists definition.

MARY MUNGER, with the Montana Nurses Association, said the proposal for the amendment to HB541 was acceptable to the nurse practitioners.

SENATE BILL 105 - EXECUTIVE ACTION:

REP. HANSON moved Senate Bill 105 BE CONCURRED IN. Rep. Sands called the question. The motion PASSED unanimously.

SENATE BILL 120 - EXECUTIVE ACTION:

REP. CODY moved Senate Bill 120 BE CONCURRED IN. The motion PASSED unanimously.

SENATE BILL 176:

REP. KITTSELMEN asked for clarification on Lines 21, 22 which referenced 37-8-202 sub 5, if this was the language that was changed in HB541. Lee Tickell said he would find out.

CONSIDERATION OF SENATE JOINT RESOLUTION 1:

Chairman Gould said that Rep. Patterson had an amendment sent to the Department of the Interior.

REP. PATTERSON moved SJR1 BE CONCURRED IN. Rep. Patterson presented amendments to SJR1 and SB18 (Exhibit 7). He said that this was dealing with Indian affairs and the Department of the Interior should have a copy of the amendment. The motion PASSED unanimously. REP. PATTERSON moved that SJR1 BE CONCURRED IN AS AMENDED. The motion PASSED with Rep. Sands voting No.

SENATE BILL 6 - EXECUTIVE ACTION:

Lee Heiman discussed the amendments to SB6. REP. CODY moved Senate Bill 6 BE CONCURRED IN. REP. CODY moved the Senate Bill 6 amendments BE CONCURRED IN. Rep. Cody asked Lee Heiman about the listing referred to in the amendments. Lee Heiman replied that this was spouse, children, relatives and closest relatives are the highest priority. The question was called for. The motion PASSED unanimously that SB6 BE CONCURRED IN. The motion PASSED unanimously that amendments to SB6 BE CONCURRED IN.

SENATE BILL 18 - EXECUTIVE ACTION:

REP. RUSSELL moved Senate Bill 18 BE CONCURRED IN. Lee Heiman explained the amendments to provide that Indian person be appointed only on review only when there was an Indian child involved. The amendments use a subsection as a model for foster parents. REP. RUSSELL moved the amendment to Senate Bill 18 BE CONCURRED IN.

REP. SANDS asked if this would require there be two foster care committees. Lee Heiman said there was one committee but that an Indian care review would have a person knowledgeable with Indian cultural matters be appointed for that review.

The question was called. The motion PASSED unanimously for Senate Bill 18 to BE CONCURRED IN. The motion for the amendments to Senate Bill 18 to BE CONCURRED IN AS AMENDED passed unanimously.

SENATE BILL 17 - EXECUTIVE ACTION:

REP. RUSSELL moved Senate Bill 17 BE CONCURRED IN. The question was called. The motion PASSED unanimously.

ADJOURNMENT: There being no further business the meeting was adjourned at 2:07.

R. BUDD GOULD, CHAIRMAN

3-5hs

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date MARCH 5, 1987

NAME	PRESENT	ABSENT	EXCUSED
REP. BUDD GOULD, CHAIRMAN	✓		
REP. BOB GILBERT, VICE CHAIRMAN			✓
REP. JAN BROWN	✓		
REP DUANE COMPTON	✓		
REP. DOROTHY CODY	✓		
REP. DICK CORNE'			✓
REP. LARRY GRINDE	✓		
REP. STELLA JEAN HANSEN	✓		
REP. LES KITSELMAN	✓		
REP. LLOYD MC CORMICK	✓		
REP. RICHARD NELSON	✓		
REP. JOHN PATTERSON	✓		
REP. ANGELA RUSSELL	✓		
REP. JACK SANDS	✓		
REP. BRUCE SIMON	✓		
REP. CAROLYN SQUIRES	✓		
REP. TONIA STRATFORD	✓		
REP. BILL STRIZICH	✓		

...TEE REPORT

MARCH 5, 19 87

We, the committee on HUMAN SERVICES AND AGING

report [redacted] JOINT RESOLUTION NO. 1

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

OPPOSING INDIAN HEALTH SERVICE REGS LIMITING ELIGIBILITY FOR HEALTH CARE

1. Page 3, line 10.
   Following: "Delegation"
   Insert: ", to the Secretary of the United States Department of the Interior,"

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 5, 19 87

Mr. Speaker: We [redacted]ittee on HUMAN SERVICES AND AGING

report [redacted] NO. 6

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

1. Page 1 line 10 through line 22 of page 2.
Strike: section 1 in its entirety
Insert: "Section 1. When organ donation may be requested.
(1) When, based on generally accepted medical standards, a hospital patiant is a suitable candidate for organ or tissue donation and has not made an anatomical gift as provided in this part, the hospital administrator or his designated representative shall request the person authorized in 72-17-201 to donate all or any part of the decedent's body as an anatomical gift. Requests shall be made in order of priority stated in 72-17-201 when persons in prior classes are not available at the time of death.
(2) Donation of all or part of the decedent's body may not be requested:
(a) if the hospital administrator or his designated representative:
(i) has actual notice of opposition to the gift by the decedent or a person in the class authorized to made a gift under 72-17-201; or
(ii) has reason to believe that an anatomical gift is contrary to the decedent's religious beliefs; or
(b) if there are medical or emotional conditions under which the request would contribute to severe emotional distress.
(3) When a request is made pursuant to this section, the request and its disposition must be noted in the patient's medical record and documented as provided in 72-[redacted]304(3)."

REP. JAN BROWN WILL CARRY THE BILL IN THE HOUSE OF REPRESENTATIVES

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 5, 19 87

Mr. Speaker: We the committee on HUMAN SERVICES AND AGING

report [redacted] NO. 18

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

1. Page 1, line 25.
Strike: "judicial district encompasses a county with"
Insert: "child who's care under review is"

2. Page 2, lines 1 and 2.
Strike: "population" on line 1 through "census" on line 2

3. Page 2, line 4.
Following: "matters"
Insert: "who is appointed effective only for and during that review"

REP. RUSSELL WILL CARRY THIS BILL IN THE HOUSE OF REPRESENTATIVES

THIRD reading copy (BLUE color)

XT. 1

STANDING COMMITTEE REPORT

MARCH 5, 1987

Mr. Speaker: We [redacted]mittee on HUMAN SERVICES AND AGING

report [redacted] NO. 17

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

REQUIRING APPOINTMENT OF AN INDIAN CHILD WELFARE SPECIALIST

REP. RUSSELL WILL CARRY THIS BILL IN THE HOUSE OF REPRESENTATIVES

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 5, 19 87

Mr. Speaker: We, the committee on HUMAN SERVICES AND AGING

report [redacted] NO. 105

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

LEGISLATIVE AUDITS OF MONTANA MEDICAL LEGAL PANEL

REP. SIMON WILL CARRY THE BILL IN THE HOUSE OF REPRESENTATIVES

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 5, 19 87

Mr. Speaker: We, the committee on HUMAN SERVICES AND AGING

report SENATE BILL NO. 120

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

REQUIRE GROUP POLICY CHEMICAL DEPENDENCY CARE BY APPROVED PERSON, FACILITY

REP. CODY WILL CARRY THE BILL IN THE HOUSE OF REPRESENTATIVES

THIRD reading copy (BLUE color)

EXHIBIT
DATE 3-5-87
SB # 105

SENATE BILL #105 Senator Himsl

AUDIT MEDICAL PANEL

Montana Medical Panel was established in 1977 for the purpose of reviewing all malpractice claims or claims against health care providers; the panel is attached to the Supreme Court for administrative purpose only.

A director is appointed by the Executive Director of the Montana Medical Association, with approval of the Chief Justice, and his salary and tenure is set by the Executive Director, again subject to approval by the Chief Justice.

The six-member panel composed of health care providers licensed in Montana sit in review of each case; 3 panel members are physicians, 3 are attorneys -- if the claim is against physicians. If the claim is against health care facilities, two of the panel must be administrators of the same type facility, one member a physician and 3 attorneys.

Panel members are selected from nominees by the professional organizations; they are paid $40 per hour plus expenses.

Funding is by trust with no money reverting to the general fund; the fund shall be open to audit by the legislative auditor.

EXHIBIT #1
DATE 3-5-87
SB #105

The fund is created by an annual surcharge levied on all health care providers; the assessment is set by the director and must be apportioned among physicians, hospitals and health care providers by group; The assessment must be proportionate to the respective percentage of total health care providers brought before the panel that each group constitutes.

Any surplus funds over and above administrative costs shall be retained by the director and carried forward to reduce subsequent assessments.

The present law allows for an audit but this legislation proposes that the audit determine the adequacy, sufficiency and reasonableness of the surcharge or assessment.

A copy of the audit must be presented to the supreme court and the cost of the audit to be paid by the panel. The first audit to be conducted for the two fiscal years ending June 30, 1987.

Exact cost is unknown of a 2 year audit - paid for by assessment not general funds.

EXHIBIT #2
DATE 3-5-87
SB #176

Montana Nurse Practitioner
State Interest Group

REIMBURSEMENT OF NURSING SPECIALISTS BY MEDICAID & HEALTH CORPORATIONS
FACT SHEET

- The original intent of SB 70, which was passed unanimously by both Houses in the 1983 Session, was to provide reimbursement to nursing specialists by all insurance companies and Medicaid. Since that time several "loop holes" have been found which are preventing reimbursement from Medicaid and health service corporations (Blue Cross, Blue Shield); the proposed bill will provide for reimbursement of currently covered services from these organizations. SB 176 does **not** add *new* services to insurance policies. Nursing specialists currently provide many services covered by BC/BS & Medicaid, but payment for services has to go to physicians or health agencies.

-Nursing "Specialists" are Nurse Practitioners, Nurse Midwives, and Nurse Anesthetists who are responsible and accountable for the quality of health services they provide, as defined in the Montana Nursing Practice Act. In order to use a nursing specialist title in Montana, the nurse must meet specific educational requirements and hold individual certification from a Board of Nursing approved certifying body.

-Nursing specialists should be directly reimbursed because:

a. they deserve to receive *directly* the money they legally earned;
b. direct reimbursement allows the consumer to obtain health care services directly from the *provider of their choice*, thus increasing access to and decreasing duplication of services;
c. nursing specialists provide *cost-effective* health care;
d. direct reimbursement provides a way to generate the statistics necessary to prove how important nursing specialists are in the health care delivery system.

-**25** States currently permit direct reimbursement of nurses' services; **18** States currently provide Medicaid reimbursement to nursing specialists.

-This Bill will be **revenue-neutral**. A poll of 34 of the 43 members of the MT Nurse Practitioner State Interest Group demonstrated that 24 nurse practitioners are in a position to bill Medicaid and Health Service Corporations; of those 24, 20 are currently billing through another mechanism, and 4 who are not billing would bill if they are able to do so directly. There are a limited number of Nurse Midwives and Nurse Anesthetists in the state who would be seeking direct reimbursement for their services. This means very few **new** providers of care will be added to the reimbursement system.

A 1986 study on the cost of reimbursement to nurse practitioners in Oregon and Maryland has demonstrated that a limited percentage of nurse practitioners in those 2 states have sought reimbursement on a fee-for-service basis. The findings also demonstrate that nurses who are being directly reimbursed charge **less** for their services; furthermore, when billing for nurses' services is done under the physician's or employer's name, charges are greater than when the reimbursement is made directly to the nurses.

-In 1981 Dr. Claire M. Fagan reviewed all the available studies on the cost-effectiveness of nurse practitioners and she concluded that nurse practitioners alter the production of health services in a way that improves access and reduces cost. She also reported that in 21 studies comparing primary ambulatory care provided by nurse practitioners and physicians, there were essentially *no differences* between the two types of health care providers in relation to outcome of illness and process of care.

SENATE BILL 176 **SPONSOR: ECK**

EXHIBIT 2-h
DATE 2-5-91
SB #176

Montana's Healthy Choice

MONTANA NURSE PRACTITIONER
STATE INTEREST GROUP

P.O. Box 5718
Helena, MT 59604

TESTIMONY SUPPORTING DIRECT REIMBURSEMENT OF NURSING SPECIALISTS
BY MEDICAID AND HEALTH SERVICE CORPORATIONS
SB 176 Sponsor - Eck

The following testimony is offered in support of Senate Bill 176 by the Montana Nurses' Association and the Montana Nurse Practitioner State Interest Group (an Interest Group of the Montana Nurses' Association).

During the 1983 legislative session Senate Bill 70 was unanimously passed by both houses of the legislature, thus providing for direct reimbursement of nursing specialists by health insurance companies, workman's compensation, and we erroneously thought, Medicaid. The intent of the bill was to provide the consumer with freedom of choice in selecting a health care provider to deliver services already covered in existing health policies or plans. Nursing "specialists" include Nurse Practitioners, Nurse Midwives, and Nurse Anesthetists who are directly responsible and accountable to the consumer for the quality of health services they provide, as defined in the Montana Nursing Practice Act [37-8-202(5)]. In order to use a nursing specialist title in Montana, the nurse must meet specific educational requirements and hold individual certification from a Board of Nursing approved certifying body.

While implementing reimbursement under Senate Bill 70 over the past four years, nurse practitioners and nurse midwives in the state have been repeatedly denied payment by Medicaid and Blue Cross and Blue Shield on the basis that Senate Bill 70 did not apply to their organizations. The Department of Social and

Rehabilitative Services has indicated that nursing "specialists" are not a reimburseable provider by Medicaid according to the Administrative Rules of Montana, despite the fact that nursing specialists provide several of the *services* that are covered by Medicaid. Blue Cross/Blue Shield has denied claims to nurse practitioners and nurse midwives because Blue Cross/Shield identifies itself as a *health service corporation* rather than an insurance company; the State Insurance Commissioner has concurred with Blue Cross/Shield's claim that Senate Bill 70 does not apply to *health service corporations*.

During the past year the Montana Nurse Practitioner State Interest Group, in conjunction with the Montana Nurses' Association, attempted to implement an Administrative Rule change through the Department of Social and Rehabilitative Services (SRS) to provide direct reimbursement to nurse practitioners. SRS refused to implement a rule change on the grounds that their Medical Advisory Committee would not approve such action. SRS advised us to take the request for reimbursement to the Legislature so the Legislature could provide them with direction for reimbursing nurse practitioners. Thus, we had no alternative but to attempt a legislative change to provide direct reimbursement for nursing specialists by Medicaid and health service corporations.

The current methods of reimbursing nursing specialists by Medicaid and Blue Cross/Shield are unfair and discriminatory. Nursing specialists currently can bill Blue Cross/Shield and Medicaid for services they have provided **only** through a physician or health care agency. When reimbursement is made in this way, there is no credit given to the nursing specialist who was the *actual* provider of the care. Under these current reimbursement mechanisms the nursing specialist who is not employed by a physician or a reimburseable health agency is forced to turn clients

EXHIBIT 2
DATE 3-5-87
SB # 176

away from care or to provide the care without compensation. This in turn denies access to care by health care consumers, promotes unfair trade practices, and creates barriers to recruiting nursing specialists to the state. Access to nursing specialists is especially important in a rural state such as Montana where nursing specialists have consistently demonstrated their ability to provide high quality care in certain geographic areas and health agencies where physicians have not been available on a regular basis. The current reimbursement mechanisms also prevent generation of the statistics and data necessary to document the contribution of nursing specialists to quality and cost-effective health care.

The proposed legislation is consistent with national trends. Twenty-five states currently provide for direct reimbursement of nurses' services; 18 states provide Medicaid reimbursement to nursing specialists. The federal government has passed legislation that enables certain nursing specialists to be directly reimbursed through the Rural Health Clinics Act and CHAMPUS.

There are unsubstantiated fears by opponents to direct third party reimbursement for nursing services that it will increase health care costs because health services will be duplicated by many nurses starting their own businesses and because new services will have to be added to current insurance policies. We predict that this bill will be **revenue-neutral** and could possibly decrease health costs in the long run. Senate Bill 176 does **not add** any new services to current insurance policies. It will provide for reimbursement of *services currently covered in the consumer's policy* if the consumer chooses to receive those services from a nursing specialist *instead of* receiving them from a physician.

A 1986 study by Griffith on the degree to which nurses are receiving reimbursement in Oregon and Maryland (states with reimbursement laws for 7 and 4 years, respectively) and the effects of the reimbursement on cost, demonstrated that a limited percentage of nurse practitioners in both those states have sought reimbursement on a fee-for-service basis, or are receiving direct third party reimbursement. The Montana Nurse Practitioner State Interest Group currently has 46 members and represents 70% of the nurse practitioners residing in Montana. A December 1986 poll of its members found that 24 of the 34 nurse practitioners who responded to the poll are in a position to bill Medicaid and health service corporations. Of the 24 who could bill, 20 are currently billing *through other mechanisms* mentioned previously, and the 4 who are not billing would bill if they could do so directly. There are a limited number of nurse midwives and nurse anesthetists in the state who would be seeking direct reimbursement for their services. Based on Griffith's study and on our own poll, we expect very few **new** providers of care to be added to the reimbursement system. Instead, payment and credit for services presently being provided by nursing specialists could go directly to the nursing specialist who provided the care rather than to the physician or agency as is the current practice.

The cost-effectiveness of nursing specialists and the quality of care they provide have been substantially demonstrated in many studies. The study by Griffith (cited above) demonstrated that nurses who are being reimbursed on a fee-for-service basis and/or are receiving direct third party reimbursement in Oregon and Maryland, charge **less** for their services. Furthermore, when billing for nurses' services was done under the physician's or employer's name, Griffith found that charges were more likely to be greater than when reimbursement was made

EXHIBIT 2
DATE 3-6-89
SB # 176

directly to the nurse. An addendum is attached which provides a summary of some of the significant findings of other studies about nursing specialists.

In summary, this proposed legislation is needed to fulfill the original intents of Senate Bill 70 and the unanimous vote of the 1983 Legislature to directly reimburse nursing specialists the money they have legally earned through the provision of health care services to the citizens of Montana. It will assure that **all** Montana consumers have access to quality, cost-effective health care services from the provider of their choice. Senate Bill 176 will also enable nursing specialists to more fully practice their profession with fewer economic and trade barriers. We respectfully urge the committee to give this Bill a "do pass" recommendation.

EXHIBIT 2-F
DATE 3-5-87
SB # 176

ADDENDUM TO TESTIMONY SUPPORTING DIRECT REIMBURSEMENT
OF NURSING SPECIALISTS BY MEDICAID & HEALTH CORPORATIONS

SUMMARY OF FINDINGS OF STUDIES ON NURSING SPECIALISTS

-In 1981 Dr. Claire M. Fagin reviewed the available studies that had been done on the cost-effectiveness of nurse practitioners and she concluded that nurse practitioners alter the production of health services in a way that improves access and reduces cost. She also reported that in 21 studies comparing primary ambulatory care provided by nurse practitioners and physicians, there were essentially **no differences** between the two types of health care providers in relation to outcome of illness and process of care.

-A national attitudinal survey published in June 1985 demonstrates that the public was very supportive of direct reimbursement for nurses with special education for providing expanded health care services. These respondents also indicated they thought the cost of services would be lowered if performed by nurses.

-Several studies have shown that nurse practitioners are more knowledgeable about patient's problems, more available, and identify more relevant signs or symptoms than physicians. In addition, nurse practitioners have been found to utilize less drug therapy, achieve better patient compliance, and provide greater follow-up when compared with physicians.

-Nurse practitioners caring for patients with chronic illnesses have demonstrated dramatic improvements in reducing blood pressure in hypertensive patients; in reducing blood sugar levels of diabetic patients; and a **50%** reduction in hospitalization.

-Following the introduction of nurse midwives into a community with previously poor pregnancy outcomes, infant mortality rates dropped significantly and pregnancy outcomes improved dramatically.

-A study done by the New York State Department of Social Services on nurses providing women's health care at the Margaret Sanger Clinic in New York City showed that the cost would be **$8,400** more per provider if services were provided by a physician.

-Health care costs have been shown to be decreased in childbearing centers utilizing nurse midwives, and in the CHAMPUS program where the reimbursement of nurse practitioners was **31%** less when compared with physician's rates.

-The Health Care Financing Administration's 1985 review of *Cost, Utilization and Productivity of Nurse Practitioners and Physician Assistants in Urban Health Centers* established that nurse practitioners/physician assistants in fee-for-service clinics are most productive in that they serve the greatest number of patients per $10,000. HCFA also cited a quality of care level comparable to similar facilities in the country.

-A December 1986 study conducted by the Congressional Office of Technology Assessment found that although nurse practitioners and certified nurse midwives provide quality, cost-effective care, they have not been utilized to their fullest potential due to third pary payment barriers. The study supports changes in third party payment mechanisms to permit full utilization of these nursing specialists.

EXHIBIT 2
DATE 3-5-87
SB # 176

ELIZABETH C. VEIGN, M.N., R.N.C.
708 15th Street South - Great Falls, MT 59405

March 5, 1987

TO: Members, House Committee on Human Services and Aging

FR: Elizabeth C. Veign, M.N., R.N.C.
Family Nurse Practitioner

RE: Testimony in support of Senate Bill 176

As a Nurse Practitioner currently providing direct patient care in Montana, I would like to provide the committee with a practical example of why Senate Bill 176 is needed. I provide well child clinic services to Chouteau and Judith Basin Counties on an average of once per week. Judith Basin County meets the new proposed Department of Health and Human Services health care delivery classification for a *frontier* area and parts of Chouteau County also qualify for this *frontier* designation. Judith Basin County has no regular physician services available in the entire county. In Choteau County, Fort Benton has 2 physicians, only one of whom accepts Medicaid clients, and Big Sandy has a semi-retired physician.

The services I provide through the well child clinics are primarily wellness-oriented. I conduct routine health histories, physical examination, developmental assessment, and provide counselling to parents about child growth and development, safety, and health care needs. Although my services are aimed at well children in the community, there has been an increase in the number of ill children being brought into our clinics. This is most likely a reflection of the current economic situation facing the state's farm population. I am more likely to see an ill child in Fort Benton on a day

when the physician who accepts Medicaid is out of town, or in Big Sandy when the physician is not available. Parents who bring their ill children to see me view me as a viable alternative to physician services. In many cases I am able to provide intervention with over-the-counter medications or routine nursing measures. If the child is in need of antibiotic therapy, say for an ear infection, I can usually contact a physician in Great Falls who will phone a prescription for the child into a local pharmacy. If the child is a Medicaid recipient, which many of my clients are, I am unable to be reimbursed for providing such care. Had the local physician been available and seen the patient, Medicaid would have reimbursed for the care. Since the client chooses to seek health care from me as an **alternative** to the physician, and I am legally capable of providing the care, then I have the right to be compensated for my services.

The Department of Health and Human Services and the National Rural Health Association are both in support of recruiting nurse specialists to rural and frontier areas as a means of improving access to quality health care services. Adequate third party reimbursement for nurse specialists is crucial to such recruitment efforts. Montanans in rural and frontier areas have demonstrated their acceptance of nurse specialists and need access to them. The nurse specialists need to have a sound economic base on which to practice. This bill will facilitate both of these goals. I hope the committee will strongly support Senate Bill 176.

EXHIBIT #7
DATE 3-5-87
SB #176

February 19, 1987

My name is Alice K. Honrud and I live in Fort Benton, Montana, with my husband and three children.

I am in support of Senate Bill #176 because it will increase access to nurse practitioners for health care services.

Sine August of 1982 to present I have utilized the services of nurse practitioners for routine health care for my two younger children. I was unaware of nurse practitioners when my first child was born in 1975. and used only pediatrician care for all immunizations and all illnesses for the first seven years of life.

Routine physicals and immunizations have been provided for my children by nurse practitioners with an occasional visit to a pediatrician for illnesses and broken bones. The visits to the pediatrician's offices reinforce my belief in nurse practitioners. My children are hardly glanced at by the doctor and the physician doesn't stay long enough to answer questions concerning our visit and never has family history been included in our visits, ie; allergies, diseases, and heredity problems. The cost of physician office visits, exams, and immunizations is tramatic and the fees our Blue Cross Insurance Company go by, doesn't cover what they claim and most of the time the insurance company will not cover any of the well baby care.

The routine health care I receive from the nurse practitioners is not only cost effective, they are extremely thorough. We have received total health care for our children and we have been treated as individuals rather than numbers for statistics. The nurse practitioner has always given the time to us that it takes to answer questions, teach us new methods of care

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for my children and they will counsel us about any concern there are for our children.

The physicals my children have received from nurse practitioners are exceptional. All areas are checked physically, histories are taken on each individual child, developmental tests are done and counseling is done at each appointment.

Immunizations are always explained in detail as far as benefits, laws, and reactions, to us everytime one of the children needs a shot. Permission slips have to be signed for each immunization that is given. If I am unsure of my child's health at the time of the immunization, the nurse practitioner will check them over quickly for possible ear infections, high temperatures, etc., before the shot is given. Never at our pediatrician's office has an immunization been explained, other than that they are required by law. The doctor will cover the basic reactions from the shots but never in depth.

I have a family health policy with Blue Cross/Blue Sheild at the present time and would like them to contract with nurse practitioners for the health services they provide. The monies the insurance company pays out should go to quality health care providers, nurse practitioners as well as physicians.

I would like to thank the committee for the opportunity to present my testimony in behalf of Senate Bill #176. Thank you.

Alice K. Howard

Montana Senior Citizens Assn., Inc.
WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE
P.O. BOX 423 - HELENA, MONTANA 59624

EXHIBIT # 5
DATE 5-5-87
SB # 176

443 5341

SB 176

The Montana Senior Citizen Association (MSCA), an organization representing over 7000 seniors in Montana, supports SB 176, the reimbursement of nurse specialists by third party payors.

MSCA supports this bill for the following reasons:

Health care accessibility. MSCA believes that if nurse specialists have a reliable means of reimbursement for their services, that one effect of this would be to encourage the practice of the profession. This is important to senior citizens because studies suggest that in areas where physicians are not available on a regular basis, it is often nurse specialists who provide health care. For seniors, many of whom live in rural areas and do not have the means to travel to major health centers, the availability of nurse specialists could mean the difference between having, or not having accessible health care.

Health care costs. Many of the activities of MSCA are directed towards the pursuit of affordable health care for all of Montana's citizens. Studies have shown the following:

1. that nurse specialists tend to charge less than physicians for providing equivalent health care. Thus measures that act to promote the profession of nurse specialists will also promote cost containment efforts.

2. that when billing for a nurse specialists' services is done under a physician's or employer's name, the charges are greater than when the reimbursement is made directly to the nurse. Again, passage of this bill, because it calls for direct reimbursement, will act as a cost containment measure.

Thus, for reasons of accessibility and cost containment, MSCA supports SB 176.

EXHIBIT 10
DATE 3-5-87
SB # 176

Montana Nurses' Association

(406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

SB 176

THE MONTANA NURSES' ASSOCIATION SUPPORTS SB 176, WHICH WOULD PROVIDE FOR THE REIMBURSEMENT OF NURSE SPECIALISTS BY MEDICAID AND HEALTH SERVICE CORPORATIONS.

SB 176, IF PASSED, WOULD FULFILL THE INTENT OF SB 70, WHICH WAS PASSED UNANIMOUSLY BY BOTH LEGISLATIVE HOUSES IN THE 1983 SESSION. THAT BILL PROVIDED FOR REIMBURSEMENT TO NURSE SPECIALISTS BY ALL INSURANCE COMPANIES AND MEDICAID BUT BECAUSE OF "LOOPHOLES" IN THE LAW, REIMBURSEMENT BY HEALTH SERVICE CORPORATIONS AND MEDICAID HAS BEEN WITHHELD. SB 176 PROVIDES FOR REIMBURSEMENT BY THOSE ORGANIZATIONS.

THE MNA FEELS THAT NURSE SPECIALISTS SHOULD BE DIRECTLY REIMBURSED FOR THE FOLLOWING REASONS:

(1) DIRECT REIMBURSEMENT ALLOWS THE CONSUMER ACCESS TO THE PROVIDER OF THEIR CHOICE;

(2) NURSE SPECIALISTS PROVIDE COST-EFFECTIVE HEALTH CARE; AND

(3) NURSE SPECIALISTS HAVE DEMONSTRATED THEIR ABILITY TO PROVIDE HIGH QUALITY CARE IN GEOGRAPHIC AREAS WHERE PHYSICIANS ARE NOT AVAILABLE. THIS POINT IS ESPECIALLY IMPORTANT IN A LARGELY RURAL STATE SUCH AS MONTANA.

FOR THE ABOVE REASONS, MNA SUPPORTS SB 176, AND URGES A DO PASS RECOMMENDATION.

RESPECTFULLY SUBMITTED,
PEGGY, MUSSEHL, PRESIDENT
MARCH 5, 1987

EXHIBIT #7
DATE 3-5-87
SB
EX ACTION

Amendments to SJR 1 and SB 18
For Executive Action, March 5, 1987
Lee Heiman

==========

Amend Senate Joint Resolution No. 1, Third Reading Copy.

Provides copy to go to Secretary of the U.S. Dept. of Interior

1. Page 3, line 10.
Following: "Delegation"
Insert: ", to the Secretary of the United States Department of the Interior,"

==========

Amend Senate Bill No. 18, Third Reading Copy

Provides appointment to committee only if child is Indian and only for that review (patterned after (1)(f) for foster child).

1. Page 1, line 25.
Strike: "judicial district encompasses a county with"
Insert: "child who's care under review is"

2. Page 2, lines 1 and 2.
Strike: "population" on line 1 through "census" on line 2

3. Page 2, line 4.
Following: "matters"
Insert: "who is appointed effective only for and during that review"

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EXHIBIT #7
DATE 3-5-87
SB # 176

Montana Hospital Association

(406) 442-1911 • P.O. BOX 5119 • HELENA, MONTANA 59604

TESTIMONY IN OPPOSITION TO S.B. 176 AS CURRENTLY WRITTEN

By Bill Leary
Montana Hospital Association

Reluctenly, must rise as an opponent to SB 176.

Not that I feel that the nurse specialists should not have the opportunity to receive reimbursement from the Medicaid program for their services and if we were still in the good old days of a state surplus of funds I would be supporting them in their efforts, however, their efforts in writing SB 176 to place their reimbursement in the mandatory (section 1_ section of the bill - the nurse spcialists are insisting that the State of Montana must appropriate money to the Department of SRS sufficient to fund their services over the next two years in spite of the financial crisis facing the STATE.

If the bill is reported out in its present form it will have to be rereferred to Appropriations.

If, however, the clause of page 1, line 21 and 22 is shifted to the optional services of Medicaid in Section 2 of the bill, perhaps as item new (k) it would allow the nurse specialists to be recognized for reimbursement the same as private-duty nurses, dental services, physicial therapists, social workers etc. and when State revenues are increased then SRS can request that nurse specialists services be paid for from the optional Medicaid funds budgeted through the Appropriation process.

If the nurse specialists are not willing to compromise on this bill in the above named suggestion then I recommend that SB 176 be killed in total.

Hurdis Griffith

Implementation of Direct Third Party Reimbursement Legislation for Nursing Services

A widely acclaimed goal of nursing is to receive direct payment from third party payers. Twenty-five states have enacted legislation enabling direct third party reimbursement for specific groups of nurses or all nurses. Yet little data exist regarding the implementation of these laws. This research explored the degree to which nurse practitioners in two states are receiving direct third party reimbursement and its relationship to charges for health-care services.

Twenty-five states have enacted legislation providing direct third party reimbursement for either specific groups of nurses or all nurses. To what degree are nurses in these states receiving direct third party reimbursement, and how has it affected health-care costs? This research addresses these questions in Maryland and Oregon, two states that passed such laws in 1979.

Methodology for Maryland Study

A case study of the implementation of legislation providing direct third party reimbursement for nurse practitioner (NP) services in Maryland was conducted in 1983, 4 years after enactment of the law. The theoretical framework for the study was the Nakamura and Smallwood (1980) theory of implementation that describes the implementation process as a system of interconnected environments and linkages. The three environments encompassed policy formation, implementation, and evaluation.

The study was conducted in two phases: exploratory and descriptive. The exploratory phase consisted of extensive open-ended interviews with a purposive sample of 13 NPs, 11 insurers, 13 legislators, 10 physicians, 5 nurse-midwives, and 6 psychiatric/mental health nurse specialists who had some involvement with the legislation's passage. A content analysis of the interviews was conducted with 91.3% interrater reliability.

In the second part of the study (the descriptive phase), questionnaires based on the content analysis of the interviews were mailed to 211 certified NPs who had written agreements with physicians that enabled them to practice in Maryland. Seventy-four percent responded to the questionnaire; 148 were practicing at the time and met the criteria for inclusion in the study.

Methodology for Oregon Study

The descriptive phase of the study was replicated in Oregon in 1986, 7 years after enactment of legislation enabling direct third party reimbursement for

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ACKNOWLEDGMENT — The author wishes to acknowledge the University of Texas at Austin, Nursing Research Center, for assistance with this study.

NPs in that state. Under the Oregon Nurse Practice Act, the term "NP" includes nurse-midwives and psychiatric/mental health nurses in addition to the other types of NPs included in the Maryland study. Therefore, the 520 NPs (including nurse-midwives and psychiatric nurses) certified to practice by the Oregon State Board of Nursing were the study population.

Questionnaires were randomly sent to half of this population (260) with a response rate of 65%. Included in the sample were 126 NPs, 18 nurse-midwives, and 23 psychiatric/mental health nurses. Findings related to nurse-midwives and psychiatric nurses are not included in this article, which focuses on comparable groups of subjects (NPs) in the two states.

Research Questions

The major research questions in these studies were:

1. What are the differences between responses of NPs in Maryland and Oregon on selected factors related to nurses receiving direct third party reimbursement (indicators of the degree that the legislation providing direct third party reimbursement for nursing services has been implemented in each state)?
2. Are the differences between the charges of NPs and physicians greater in a state where legislation providing direct third party reimbursement has been implemented than in another state in which similar legislation has not been implemented?
3. Is there a significant difference (α.05) between the charges for services of NPs who are salaried and those who are reimbursed on a fee-for-service basis?
4. Is there a significant difference (α.05) between the charges for services of NPs who receive direct third party reimbursement and those who do not?

Sample Characteristics

Some sample characteristics that were explored in this study included: type of NP program completed, highest educational degree, years of practice experience, and number of patient contacts.

The type of specialty program completed varied between the two states and probably reflected the national trend away from continuing education programs toward master's degree preparation. In 1983, 78% of Maryland NPs had received their NP preparation in continuing education programs; in 1986, only 49% of Oregon NPs had become NPs through continuing education (see Table 1). The highest degree held by the respondents reflected a similar national trend for specialty nurses to have master's level preparation; whereas in 1983, the majority of NPs in Maryland had associate degrees, or baccalaureate degrees, the majority of NPs in Oregon in 1986 had a master's degree (see Table 2).

In both Maryland and Oregon, respondents were relatively experienced practitioners; the highest percentages in both states had practiced in their specialty area for 5 to 10 years (see Table 3).

The number of patient contacts during the past 6 months was compared between the respondents in the two states. Generally, Oregon NPs had fewer patient contacts than Maryland NPs (see Table 4).

Factors Related to the Implementation of the Legislation

Five factors were explored that may be indicators of the degree to which the legislation had been implemented at the times of the studies: (a) physician supervision, (b) claims submitted to third party payers, (c) provider numbers, (d) method of reimbursement, and (e) direct third party reimbursement. Each indicated that the degree to which the law had been implemented in Oregon (7 years after passage in 1986) was greater than the degree to which the law had been implemented in Maryland (4 years after passage). Findings on these factors follow.

Physician supervision. The assumption was made that there would be an inverse relationship between the amount of physician supervision and propensity toward being directly reimbursed by third party payers. The percentage of NPs always working under the supervision of a physician was nearly four times greater in Maryland than in Oregon (see Table 5).

Claims submitted to third party payers. Thirty-one percent of Maryland NPs responded that claims were submitted to third party payers to cover charges for services provided when consumers were eligible for coverage. Sixty-eight percent of Oregon NPs responded that claims were submitted for their services (see Table 6).

Whether or not NPs sign the claim forms for their services may also be an indicator of the degree to which the legislation has been implemented. The differences between the states on this question were great. While only 9% of Maryland NPs were signing their claim forms, 37% of Oregon NPs were signing claim forms for their services.

Provider numbers. Because provider numbers from insurers are required to submit for third party reimbursement, the degree to which nurse providers are applying for and receiving provider numbers from third party payers is also an indication of the implementation of the law. Although only 3% of Maryland

Table 1. Type of NP Program

Program Type	Oregon ($\bar{N}$ = 126) %	Maryland ($\bar{N}$ = 148) %
Continuing education	49.2	78.4
Master's	48.4	20.9
Both	1.6	—
No response	0.8	0.7
Total	100.0	100.0

Table 2. Highest Degree Held

Degree	Oregon ($\bar{N}$ = 126) %	Maryland ($\bar{N}$ = 148) %
Associate	3.2	2.7
Diploma	4.8	29.1
Baccalaureate	34.9	33.8
Master's	57.1	33.8
Doctoral	—	—
No response	—	0.7
Total	100.0	100.0

Table 3. Years of Practice

Years of Practice	Oregon ($\bar{N}$ = 126) %	Maryland ($\bar{N}$ = 148) %
Less than 1 year	7.9	2.0
1-4 years	24.6	37.8
5-10 years	48.4	52.0
More than 10 years	19.0	7.4
Not working as NP	—	0.7
Total	100.0	100.0

Table 4. Patient Contacts Over a 6-month Period

Numbers	Oregon ($\bar{N}$ = 110) %	Maryland ($\bar{N}$ = 139) %
50-600	42.8	27.4
601-1,200	34.6	30.2
1,201-1,600	12.7	21.6
Over 1,600	9.1	20.8
No response	0.9	—
Total	100.0	100.0

Table 5. Frequency of Physician Supervision

Frequency	Oregon ($\bar{N}$ = 124) %	Maryland ($\bar{N}$ = 145) %
Always	4.8	18.6
Frequently	20.2	29.0
Seldom	48.4	44.8
Never	26.6	7.6
Total	100.0	100.0

Table 6. Claims Submitted for NP Services

Submission Process	Oregon ($\bar{N}$ = 111) %	Maryland ($\bar{N}$ = 140) %
Claims submitted	67.6	30.7
Claims not submitted	23.4	52.1
Do not know	9.0	17.1
Total	100.0	100.0

Table 7. Method of Reimbursement

Reimbursement Method	Oregon ($\bar{N}$ = 122) %	Maryland ($\bar{N}$ = 147) %
Salary	75.4	97.3
Fee-for-service	13.1	2.0
Not working as NP	7.4	0.7
Both salary & fee-for-service	2.5	—
Other	1.6	—
Total	100.0	100.0

Table 8. Comparing NP Fees with Physician Fees

Fee Comparisons	Oregon ($\bar{N}$ = 126) %	Maryland ($\bar{N}$ = 138) %
NP fee less than physician's fee	36.5	11.6
NP fee more than physician's fee	2.7	—
NP fee same as physician's fee	16.2	63.0
No charge for both	23.0	7.2
Do not know	14.9	18.2
Other	6.8	—
Total	100.0	100.0

Table 9. Median Charges for NP and Physician Visits

Categories of Charges	Oregon NP	Oregon MD	Maryland NP	Maryland MD	Differences Oregon	Differences Maryland
Long initial visit	$55 (68)	$65 (33)	$50 (62)	$56 (63)	$10	$ 6
Short initial visit	25 (63)	30 (30)	22 (51)	25 (50)	5	3
Long follow-up visit	36 (58)	38 (27)	32 (57)	35 (56)	2	3
Intermediate follow-up visit	25 (57)	27 (29)	23 (48)	25 (48)	2	2
Brief follow-up visit	15 (59)	18 (30)	13 (49)	15 (50)	3	2
Same charge for all visits	22 (9)	28 (6)	20 (20)	30 (21)	6	0
Total					$30	$16

(Number of respondents in parentheses)

Table 10. Differences Between Mean Charges of Oregon NPs Who are Salaried and Those Receiving Fee-for-Service

Categories of Services	Salaried	F/F/S[a]	T-Test (separate variance estimates)
Long initial visit	$60 (51)	$45 (10)	.07
Short initial visit	29 (46)	19 (10)	.003[b]
Long follow-up visit	35 (41)	42 (10)	.32
Intermediate visit	25 (42)	24 (9)	.98
Brief follow-up visit	17 (43)	13 (9)	.04[b]

[a]F/F/S = Fee for service
[b]Significant difference (α.05)
(Number of respondents in parentheses)

Table 11. Difference Between Mean Charges of Oregon NPs Who Have Received Direct Third Party Reimbursement and Those Who Have Not

Categories of Services	Have Not Received Direct Third Party Reimbursement	Received Direct Third Party Reimbursement	T-Test (Separate Variance Estimates)
Long initial visit	$61 (44)	$49 (20)	.07
Short initial visit	31 (40)	20 (20)	.001[a]
Long follow-up visit	35 (38)	39 (17)	.51
Initial follow-up visit	26 (37)	23 (17)	.35
Brief follow-up visit	18 (39)	14 (17)	.04[a]

[a]Significant difference (α.05)

NPs had provider numbers, 41% of Oregon NPs had provider numbers.

Method of reimbursement. Generally, nurses who are being reimbursed on a fee-for-service basis would be more likely to receive direct third party reimbursement than salaried nurses. The majority of NPs in both states responded that they were salaried. However, the percentage receiving fee-for-service was much greater in Oregon; 13% of Oregon NPs were receiving fee-for-service as compared to 2% of Maryland NPs (see Table 7).

Direct third party reimbursement. Although most NPs in both states were not receiving direct third party reimbursement at the times of these studies, the percentage receiving direct reimbursement was much higher in Oregon than in Maryland. Twenty-one percent of Oregon NPs responded that they had been directly reimbursed by a third party payer in contrast to less than 1% of Maryland NPs.

Comparing charges for NP and physician services. One reason often cited in support of direct third party reimbursement for nursing services is that it

would lower health-care costs. From the previous data, one could surmise that the legislation had not been implemented at the time of the Maryland study, whereas the Oregon legislation had been partially implemented. If charges for health-care delivered by NPs as compared to physicians were lower in Oregon than in Maryland, one factor associated with the difference could be the degree to which the legislation had been implemented.

When NPs in both states were asked how their charges compared with physician charges, there was a distinct difference in the responses between the two states. Three times as many NPs in Oregon, as compared to Maryland, stated that their charges were less than physician charges. Sixty-three percent of Maryland NPs stated that their charges were the same as physician charges in contrast to only 16% of the Oregon NPs (see Table 3).

When asked to record actual charges for both NP services and physician services, six categories of services were presented on the questionnaire: (a) long initial visits, (b) short initial visits, (c) long follow-up visits, (d) intermediate follow-up visits, (e) brief follow-up visits, and (f) the same charge for all visits. The differences between the medians of NP and physician charges were greater in Oregon as compared to Maryland in four of the six types of visits specified (see Table 9). For example, for long initial visits, the differences between the medians of the charges of NPs and physicians were $10 in Oregon as compared to $6 in Maryland.

Differences in charges of salaried and fee-for-service NPs. Only Oregon data could be used to compare the differences in charges between salaried and fee-for-service NPs because the Maryland NPs were not being reimbursed on a fee-for-service basis.

Among Oregon NPs who were salaried by their employers, the mean of charges collected for their services were higher in four service categories than the mean of the charges for NP services compensated on a fee-for-service basis. There was a statistically significant difference between the means of the charges of NPs who were salaried and those receiving fee-for-service on two types of services: short initial visits and brief follow-up visits (see Table 10).

Differences in charges of NPs who have received direct third party reimbursement and those who have not. The findings pertaining to this area were very similar to the findings on the previous question. The means of the charges of NPs who had not received direct third party reimbursement were greater in four of the five categories of services as compared to NPs who had received direct third party reimbursement for their services. The differences between these two groups were significant on the same two categories of services as above: short initial visits and brief follow-up visits (see Table 11).

Summary of Results

The first research question addressed differences between responses of NPs in Oregon and Maryland on five factors related to nurses receiving direct third party reimbursement. These factors were also indicators of the degree to which the legislation had been implemented in each state.

Oregon NPs were generally receiving less direct physician supervision than Maryland NPs. This would seem to indicate that Oregon NPs were more autonomous and thereby in a better position to receive direct third party reimbursement.

Twice as many Oregon NPs responded that claims were submitted to third party payers for their services as compared to Maryland NPs. Four times as many Oregon NPs were signing claim forms for their services. Forty-one percent of Oregon NPs had provider numbers as compared to only 3% of Maryland NPs. Thirteen percent of Oregon NPs were receiving fee-for-service compared to only 2% of Maryland NPs. Likewise, 21% of Oregon NPs had been directly reimbursed by third party payers compared to less than 1% of those in Maryland. Clearly, based on these factors, the legislation had not been implemented in Maryland 4 years after enactment but was at least partially implemented in Oregon 7 years after enactment.

Based on the findings that one state had implemented the legislation at the time of the study and the other had not, the second research question referred to the differences between charges of NPs in the two states. The percentage of NPs responding that their charges were less than physician charges was three times greater in Oregon than in Maryland. When asked to list their charges and the physician charges for six categories of visits, the differences between the NP and physician median charges were greater in Oregon, as compared to Maryland, in four categories of visits.

Only Oregon data could be used to address the third and fourth research questions. The third research question explored the difference between charges for services of Oregon NPs who were salaried and those reimbursed on a fee-for-service basis. The fourth research question examined the difference between Oregon NPs who had received direct third

party reimbursement and those who had not. Findings revealed that for both groupings (salaried compared to fee-for-service and those receiving direct reimbursement compared to those not receiving it), there were significant differences between the groups' mean charges in two categories of services.

The findings related to service charges indicated that in a state where direct third party reimbursement for nursing services has been partially implemented, NPs are charging less for their services and the differences are greater between physician and NP charges. In addition, the study revealed that when NPs receive fee-for-service and direct third party reimbursement for their services, some of their charges are less than when they are salaried.

Study Limitations

Because these studies were conducted 3 years apart, the findings could be attributed to the dramatic changes in the health-care system that occurred during this period. Another study limitation was that the results should be interpreted as exploratory on the last two research questions because of the small numbers receiving fee-for-service and direct third party reimbursement.

Policy Implications of the Study

Two concerns are often voiced in the federal and state legislative arenas by those opposed to the passage of legislation providing direct third party reimbursement for nursing services. First, some fear that if the legislation is enacted, many or all nurses will start their own businesses and begin charging fee-for-service, thereby increasing the numbers of fee-for-service providers and health-care delivery costs.

Findings from these two studies indicate otherwise. Four years after legislation was passed enabling direct third party reimbursement for NP services in Maryland, 2% of NPs were being reimbursed on a fee-for-service basis and less than 1% of eligible NPs had received direct third party reimbursement. In Oregon, 7 years after enactment of the legislation, only 13% of the NPs were being reimbursed on a fee-for-service basis, and only 21% had received direct third party reimbursement.

Although NPs generally want the option of receiving direct third party reimbursement, most are socialized as salaried employees and are very cautious in changing their reimbursement status. Clearly, they are not going to "come out of the woodwork in large numbers and hang out their shingles if directly reimbursed" as frequently charged in the legislative arena by opponents of this type of legislation.

Second, there is the unsubstantiated charge that providing direct third party reimbursement for nursing services will increase health-care costs. Findings from this study indicate that nurses who are being reimbursed on a fee-for-service basis and/or are receiving direct third party reimbursement charge less for their services than nurses who are salaried. When the billing for the nurse's services is done under the physician's or employer's name (a middleman), charges may be greater than when the reimbursement is made directly to the nurse. $

REFERENCE

Nakamura, R., & Smallwood, F. (1980). *The politics of policy implementation*. New York: St. Martin's Press.

Medical Indigency: Annotated Bibliography

Continued from page 298

Uncompensated hospital care presents a challenge to federal and state legislators, hospitals, physicians, and society. Data from the 1982 American Hospital Association's Annual Survey of Hospitals show that 6% of community hospital charges were uncompensated care costs amounting to $6.2 billion.

The amount of uncompensated care, however, is not equally distributed among hospitals. Some institutions, particularly publicly sponsored ones, are being forced to bear an increasingly larger share of the burden. In this paper, the dimensions of the problem and the possible policy options are discussed. The author emphasizes that market-oriented medical care reforms cannot succeed without more explicit treatment of the uncompensated care issue.

Medical Indigency: A Problem to be Corrected

The problem of medical indigency has emerged as a major health policy problem during the 1980s. In looking ahead to the next decade, the present economic situation combined with the escalating costs of health care only seem to heighten this emerging crisis. In appraising this issue today, we must look toward the health-care system of the next decade — not just the day after today. If we institute new programs and policy changes based on the status of medical indigency today, might it be possible that by 1995 medical indigency will be a thing of the past? $

EXHIBIT #9 3-5-87
DATE 3-5-87 LEE Heimin
SB #

Effect of Suggested Technical Amendments to SB 6
Mock section to read after amendment. Shows ~~existing~~ language, uncapped as appropriate, and language struck in bill eliminated.

Section 1. When organ donation may be requested. (1) When, based on generally accepted medical standards, a hospital patient is a suitable candidate for organ or tissue donation and has not made an anatomical gift as provided in this part, the hospital administrator or his designated representative shall request the person authorized in 72-17-201~~,~~ to donate all or any part of the decedent's body as an anatomical gift. Requests shall be made in order of priority stated in 72-17-201 when persons in prior classes are not available at the time of death ~~and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, to donate all or any part of the decedent's body as an anatomical gift.~~

To make clear sentence

moved

(2) Donation of all or part of the decedent's body may not be requested:

covered

(a) if the hospital administrator or his designated representative:

(i) has actual notice of opposition to the gift by the decedent or a person in the class authorized to made a gift under 72-17-201; or

(ii) has reason to believe that an anatomical gift is contrary to the decedent's religious beliefs~~,~~; or

moved

(b) if there are medical or emotional conditions under which the request would contribute to severe emotional distress~~,~~ ~~donation of all or part of the decedent's body may not be requested.~~

(3) When a request is made pursuant to this section, the request and its disposition must be noted in the patient's medical record and documented as provided in 72-17-204(3).

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Amend Senate Bill 6, Third Reading (blue) Copy

1. Page 1 line 10 through line 22 of page 2.
Strike: section 1 in its entirety
Insert: "Section 1. When organ donation may be requested.

(1) When, based on generally accepted medical standards, a hospital patient is a suitable candidate for organ or tissue donation and has not made an anatomical gift as provided in this part, the hospital administrator or his designated representative shall request the person authorized in 72-17-201, to donate all or any part of the decedent's body as an anatomical gift. Requests shall be made in order of priority stated in 72-17-201 when persons in prior classes are not available at the time of death.

(2) Donation of all or part of the decedent's body may not be requested:

(a) if the hospital administrator or his designated representative:

(i) has actual notice of opposition to the gift by the decedent or a person in the class authorized to made a gift under 72-17-201; or

(ii) has reason to believe that an anatomical gift is contrary to the decedent's religious beliefs; or

(b) if there are medical or emotional conditions under which the request would contribute to severe emotional distress.

(3) When a request is made pursuant to this section, the request and its disposition must be noted in the patient's medical record and documented as provided in 72-17-204(3)."

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VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SENATE BILL NO. 176 DATE MARCH 5, 1987

SPONSOR SEN. ECK

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Rita Klingensmith	Helena, MT	[illegible]	
C. Camparoli	Livingston	X	
[illegible]	Helena	X	
B. Veign	Great Falls	X	
Eileen Robbins	Helena	X	
Margo Caldwell	Helena	X	
[illegible]	Townsend	X	
Judy [illegible]	Belgrade	X	
[illegible]	Bozeman	X	
[illegible]	[illegible]	/	
[illegible]	Helena SRS	[illegible]	
[illegible] Nelson	" "	[illegible]	
Bob Olsen	" "	[illegible]	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SENATE BILL NO. 120 DATE MARCH 5, 1987

SPONSOR SEN. REGAN

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Mona Jamison	Helena (Forest Landowners Assn)	✓	
CHUCK DUTTA	Blue Cross/Blue Shield	-	
Bob Gleaton	MSLA		
Kathy Filius	MSLA		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SENATE BILL NO. 105 DATE MARCH 5, 1987

SPONSOR SEN. HIMSL

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Elmer J Doerfler	Helena	✓	
Roberta Harvell	Kalispell		
Kathy Kuncla	Msla		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.