

White Paper:
Advanced Practice Nurse Reimbursement and Scope of Practice in Indiana
Submitted by the Nursing Practice Action Committee-
APN Reimbursement work group of
The Indiana Action Coalition: Transforming Health Care

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Indiana Action Coalition: Transforming Health Care

White Paper: Advanced Practice Nurse Reimbursement and Scope of Practice in Indiana

Executive Summary

In its landmark October 2010 report *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine (IOM) provided a blueprint for transforming the nursing profession to improve health care and meet the health needs of diverse populations. This two year effort led by Donna Shalala PhD, former U.S. Secretary of Health and Human Services under President Clinton, and an 18-member IOM committee, identified solutions to the challenges facing the nursing profession and built upon nursing-based solutions to improve quality and transform the way Americans receive health care. Robert Wood Johnson Foundation in collaboration with AARP launched *The Future of Nursing: Campaign for Action* initiative in November 2010 which builds on the IOM report at state and local levels. Each state Campaign for Action works to implement these key recommendations:

- 1) Strengthen nurse education and training
- 2) Enable nurses to practice to the full extent of their education and training
- 3) Advance inter-professional collaboration to ensure coordinated and improved patient care
- 4) Expand leadership ranks to ensure that nurses have voices on management teams, in boardrooms and during policy debates; and
- 5) Improve health care workforce data collection to better assess and project workforce requirements

In this report the IOM committee recognized the key importance of issues of scope of practice and reimbursement for Advanced Practice Nurse (APN) services in creating or removing barriers to access to care while controlling health costs. Throughout its discussion on scope of practice barriers it calls for removing barriers in reimbursement to APNs by Medicare, Medicaid, and private third party payers. Similarly, in its discussion of expanding opportunities for APNs to lead collaborations, it calls for private and public funders to develop models of payment for nurse led collaborative patient centered healthcare models (IOM Report, 2010).

The focus of this document is to present reimbursement and scope of practice issues as they pertain to APNs in Indiana. Viable strategies are identified that would allow APNs to practice to the full extent of their education and training, thereby addressing at least one of the key recommendations of the IOM report.

While there are numerous recommendations from each APN group presented, several will be foundational priorities for all APNs to remove reimbursement and scope of practice barriers. The key legislative priorities include removing the collaborative practice agreement requirement for prescriptive authority and equitable reimbursement for APNs, regardless of practice site, for comparable services provided by other qualified health professionals. Regulatory changes in Medicaid, Hoosier Healthwise, HIP and traditional health insurances, as well as inclusion in the Indiana Health Insurance Exchange Program that identify nurse practitioners (NPs) and Certified

Nurse-Midwives (CNM) as primary care providers are necessary to allow needed increased access to quality primary care services for Indiana. Additional regulatory changes that authorize APNs to certify patients for home health services, refer to services provided by physical therapists, admit patients to hospitals, hospice and skilled care facilities are necessary to fully appreciate the contributions of APNs. Working with Indiana Department of Insurance to develop a more equitable allocation of risk for APNs based on the number of compensated claims (true risk) will ensure a more reasonable environment for APN practice.

Advanced Practice Nurses- Background: Advance practice registered nurse (APN or APRN) is a term used to encompass certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), and nurse practitioner (NP). Direct clinical practice is a core competency of any APN role, although the actual skill set varies according to the needs of the patient population (Hameric, Spross, & Hansen, 2005). APNs build on the competence of the RN skill set and demonstrate a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and significant role autonomy. The APN is prepared to assume responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and non-pharmacologic interventions (American Association of Colleges of Nursing, 2006).

APNs finish specific specialty graduate programs that include focused education and training and on-site practice experience all of which are needed to complete a national certification examination which is necessary to practice in most states (Newhouse, 2011).

In 2004, the number of registered nurses (RNs) prepared to practice in at least one advanced practice role in the United States was estimated to be 240,461, or 8.3% of the total RN population, the largest group being NPs followed by CNSs. The APN movement has been growing rapidly with APNs in every sector of health care. According to the Bureau of Labor Statistics, the demand for APNs is expected to continue to increase over the next decade and beyond, as the need and demand for effective health care increases, especially in rural, urban and other underserved areas (Bureau of Labor Statistics, 2007).

IOM Support of APNs: With the predicted shortage of primary care as the population grows and millions of people become newly insured in 2014, the IOM report supports expanding the role of the APN to allow them to provide a wider range of preventive and acute health care services. Specifically, the IOM report recommends state legislatures reform scope-of-practice laws and regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules, which outlines scopes of practice for advanced practice registered nurses. The IOM further supports reimbursement equity and that the Federal Trade Commission identify anticompetitive regulations without affecting the health and safety of the public and to encourage states to change these policies.

Legislation: Some physician groups voice concerns over safety and quality of APN services. While these concerns are being discussed at the state level, many states (21 to date) have passed legislation that allows APNs to diagnose, treat and prescribe medications without physician involvement. Although the remaining states require differing levels of physician involvement, many of these states are actively pursuing legislation to lift the scope of practice barriers to allow

improved access to care. At the federal level, policy changes are being recommended to fully reimburse APNs for the care they provide (Health Policy Brief, October 25, 2012).

Supervisory or collaborative clauses in state nursing practice acts, lead to the ineffective use of APNs. Research on the safety and effectiveness of APN practice shows these clauses are unnecessary and ultimately, force physicians to expand their legal liability in the event of professional malpractice. Claimants sue not only the person responsible but also the associated individual/entity with added malpractice insurance, thus supporting one explanation for the higher medical malpractice rates in those states with supervisory or collaborative clauses. APNs have the necessary statutory and disciplinary mechanisms, and professional associations to regulate their practice (Lee, 2011).

Challenges/Solutions: Although healthcare costs continue to grow unsustainably, healthcare policymakers earnestly seek ways to make healthcare work better, cost less, and be of higher quality. To add to the crisis, many Americans have insufficient access to primary care. The Health Resources and Services Administration (HRSA), the federal agency responsible for improving access to health care services for the uninsured, isolated, or medically vulnerable, has identified over 5,000 geographic areas with over 55 million people as Primary Care Health Professional Shortage Areas. These areas alone would need more than 15,000 additional practitioners to meet their basic health care needs (Health Affairs 2010; 2012).

With the changes in demographics including aging of the US population, implementation of the Affordable Care Act, reduced interest in primary care among medical graduates and a movement to restructure the delivery of primary care APNs are in a unique position to help meet the current and future health care needs of our nation. While controlling cost is complex and multifaceted the way we reimburse for volume clearly needs to be reformulated. A number of concepts such as ACOs (Accountable Care Organizations) and “medical homes” are being implemented or considered to test new models of reimbursement and delivery. These merging models of primary care delivery and reimbursement focus on comprehensive, patient-centered care and emphasize elements of care such as care coordination and health promotion that have been traditionally provided by nurses. Consequently, these models will need the leadership of nursing and especially APNs to ensure their success. Nurse-managed health care centers are representative of a model of health care delivery that promotes these key care elements. Notably, HRSA has awarded \$245 million dollars for nurse-managed health care centers, educational expenses for nurse practitioners and clinical training demonstration projects since 2010 (Health Affairs 2010; 2012).

APN Quality/Safety/Economic Value: Landmark research published over the past three decades underscores the value of APNs in advancing the IOM recommendations. Abundant research has been published describing and evaluating the services APNs provide. The studies have been developed and completed by nurses, physicians, economists, and many other health care and consumer researchers and have been funded by private, federal and local dollars. The studies have shown positive outcomes in every area of APN practice and have been overwhelmingly encouraging of the evolving APN roles.

A meta-analysis published in 2011 in *Nursing Economic\$* extending over 18 years, compared care provided by advanced practice registered nurses (APNs) to care provided by physicians. The quality of care was compared in 24 different categories and the results found clinical outcomes similar. APNs performed equal to physicians in 13 categories, APNs performed better than physicians in 11 categories (e.g., measures related to patient follow-up; time spent in consultations; provision of screening; assessment and; counseling services), while physicians did not outperform APNs in any categories. “The results indicate APNs provide effective and high-quality patient care, have an important role in improving the quality of patient care in the United States, and could help to address concerns about whether care provided by APNs can safely augment the physician supply to support reform efforts aimed at expanding access to care” (Newhouse, 2011).

To date, physician delivered care is the focus of pay-for-performance initiatives. As quality data is embedded in the health information systems it is imperative that APNs are involved in the development of quality measures and the inclusion of APN practice as distinct from that of other providers. The ANA database on nurse sensitive indicators is being built at the inpatient level in hospitals, while many APNs practice in settings outside hospitals. The need to create APN sensitive measures in a variety of settings is therefore paramount. As Medicare gathers evidence on effective strategies to help align quality incentives through payment, it will phase in new payment systems intended to promote transformational quality improvement in the health care industry. APNs have an enormous opportunity to showcase their ability to be innovative, efficient and promote coordination of care across time and settings. These activities are central to APN practice and have been undervalued and invisible in the-fee-for-service model (O’Grady, 2007).

The growth of the advanced practice nurse specialty roles can be credited to core values of the nursing profession, its commitment to excellence and patient safety with a willingness to provide services when and where needed and the provision of those services at a reasonable cost.

Advanced Practice Nurses in Indiana

Certified Registered Nurse Anesthetists (CRNAs)

Certified Registered Nurse Anesthetists (CRNAs) are Advanced Practice Registered Nurses (APRNs) who personally administer more than 32 million anesthetics to patients each year in the United States (American Association of Nursing Anesthetists (AANA) Practice Profile Survey, 2010). They are qualified to make independent judgments concerning all aspects of anesthesia care based on their education, licensure and certification. CRNAs are legally responsible for the anesthesia care they provide, and are recognized in state law in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands (O’Grady, 2007; AANA, 2010).

The AANA is the professional association for 44,000 CRNAs and student nurse anesthetists (AANA, 2011). Nurse anesthetists have provided anesthesia in the United States for nearly 150 years, and high-quality, cost-effective CRNA services continue to be in high demand.

Scope of Practice: The CRNAs are expected to practice based on the AANA Scope and Standards for Nurse Anesthesia Practice and also the AANA Code of Ethics. CRNAs' scope of practice is dynamic and evolving, with the institutional credentialing and privileging process being usually administered by the medical staff or other equivalent.

CRNA privileges and responsibilities must be consistent with law and may, without limitation, include the following: pre-anesthetic preparation and evaluation of the patient, intra-operative care, post anesthesia care, clinical support functions and special diagnostic requests. Other additional non clinical responsibilities may include administrative/management duties, quality assessment work, educational programs, research projects, committee appointments, inter-department liaison and clinical oversight of other departments.

CRNAs are Medicare Part B providers and since 1986, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100% of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces with CRNAs being the main providers of anesthesia care to U.S military personnel (<http://www.aana.com/aboutus/>).

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the principal anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.

Licensing and Certification: In Indiana, CRNAs practice under their RN license (see Indiana Code 25-23-1-1.4) but they are not listed specifically as a type of Advance Practice Nurse in the Nurse Practice Act.

One of the earliest official recordings of the Indiana Association of Nurse Anesthetists (IANA) dates back to 1937. Thirteen CRNA members from various locations throughout the state were listed in the 1938 IANA Journal. Membership rosters from 1938-1951 indicated a slow but steady growth, and that trend continues today. In 2012, the number of active practicing CRNAs is 263. A CRNA educational program existed in Indiana for a brief period of time between 1954-1963 at Ball State Memorial Hospital in Muncie.

There is also a provision for CRNA practice in the Indiana Medical Practice Act (Indiana Code 25-22.5-1-2) initially introduced in 1973, that states "A Certified Registered Nurse Anesthetist may administer anesthesia if the certified registered nurse anesthetist acts under the direction of and in the immediate presence of a physician."

Presently, the CRNAs must obtain a minimum of 40 hours of approved continuing education every two years in order to recertify. Newly established recertification requirements will take effect January 2016 (www.nbcrnapc.com). In June 2007, the AANA Board of Directors

unanimously adopted the position of supporting doctoral education for entry into nurse anesthesia practice by 2025.

In Indiana, although CRNAs are not eligible for prescriptive authority, they may administer anesthesia without this authorization specified in the NPA (Nurse Practice Act). The "traditional" practice of nurse anesthetists - ordering and directly administering controlled substances and other drugs preoperatively, intra operatively, and postoperatively - does not constitute "prescribing" under federal law (21 CFR 1300.01(b)(35)). Because the Drug Enforcement Administration (DEA) has not regarded traditional CRNA practice as "prescribing" under federal law, most nurse anesthetists have not had to register with the DEA.

Reimbursement: CRNAs are eligible to receive direct reimbursement for their services from Medicare, Medicaid, the Civilian Health and Medical Program of Uniformed Services (CHAMPUS), and numerous private insurers and managed care organizations. Nurse anesthetists were the first nursing specialty to be granted direct reimbursement rights under Medicare Part B (Signed into law by US President Reagan in October 1986).

CMS rule identifying conditions of participation and/or coverage for Hospitals, Critical Access Hospitals and Ambulatory Surgical Centers includes a physician supervision requirement for CRNAs. In 2001 CMS published a final rule that allowed states to opt out of this requirement. There are currently 17 states that have engaged the opt-out requirement (Indiana has not taken advantage of this opt out requirement). This allows facilities to bill and collect for anesthesia/related services administered by CRNAs working without physician supervision.

Nationally, pain management procedures provided by CRNAs have been argued. Within the past 10 years, there have been states where legislation or proposed rules have been aggressively introduced at the request of physician specialty groups, attempting to restrict CRNA interventional pain management practices. Some affected states were Louisiana, Alabama, Tennessee and Missouri. The Federal Trade Commission (FTC) intervened on behalf of the CRNAs in three of the states.

On November 1, 2012 the CMS issued a final ruling on Medicare coverage of chronic pain management services provided by CRNAs, effective January 1, 2013. The ruling expands Medicare coverage of services within CRNA scope of practice by stating that "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in that state in which the services are furnished".

In Indiana in 2004, Medicare suspended payment to CRNAs for fluoroscopic guidance for needle placement for spinal injections and for procedures of lumbar facet injection and lumbar discography. Prior to this time these procedures were reimbursable for CRNAs. The Indiana and Kentucky Boards of Nursing were consulted and Indiana could not determine if this was within the CRNA scope of practice and Kentucky determined that it was. CRNAs may bill incident to a physician for these procedures in Indiana.

In August of 2011, a group of medical specialties, in Indiana, convened a "pain management task force" with the purpose of restricting scope of practice for non-physician providers in pain

management. The group dropped the proposed actions in January of 2011 – after the FTC published its letter on behalf of the CRNAs in Alabama in November of 2010.

In Indiana, CRNAs are not allowed to work under the direction of podiatrists or dentists (these practitioners are not recognized as “physicians” under Medical Practice Act) which has limited the ability of these professionals to utilize CRNAs to provide anesthesia to their patients in certain hospital settings, ambulatory surgery centers and offices. Many states allow the provision of anesthesia by CRNAs for podiatrists and dentists.

CRNAs have an impressive malpractice insurance history that reflects their excellent safety record. The premiums have declined dramatically over the last 20 years despite a general rise in jury awards against healthcare professionals. The average 2010 malpractice insurance premium for self-employed CRNAs was 33 percent less than it was in 1988 (AANA Insurance Services).

Quality/Safety/Economic Value: While healthcare costs continue growing unsustainably, healthcare policymakers continue to seek ways to make healthcare work better, cost less, be more accessible to patients, and be of higher quality. Landmark research published recently underscores the value of CRNAs in advancing toward these crucial objectives.

- Though many studies have demonstrated the high quality of nurse anesthesia care, the results of a new study published in *Health Affairs* by Dullishe and Cromwell, led researchers to recommend that **costly and duplicative supervision requirements for CRNAs be eliminated**. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes for nearly 500,000 hospitalizations, in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. The researchers found that anesthesia has continued to grow more safe in opt-out and non-opt-out states alike. Reviewing the study, the New York Times stated, “In the long run, there could also be savings to the health care system if nurses delivered more of the care.”
- **Among all anesthesia delivery models – anesthesia delivered by CRNAs, or by physicians, or by both together -- nurse anesthesia care is extremely safe and 25 percent more cost-effective than the next least costly model**, according to a Lewin Group study published in *Nursing Economics*. Because CRNAs safely provide the full range of anesthesia services, requirements for additional supervision drive additional healthcare costs that can be saved or allocated elsewhere in the health system, while maintaining a high standard of quality and patient safety.
- To ensure patient access to high quality care, a new *Institute of Medicine (IOM)* report recommended that, “**Advanced practice registered nurses should be able to practice to the full extent of their education and training.**” By eliminating regulatory and other policy barriers to the use of advanced practice registered nurses (APRNs), including CRNAs, the healthcare system makes the most efficient use of the available workforce of healthcare professionals. This ensures patient access to high quality care, and promotes local control of healthcare delivery.

- **There is no difference in complication rates or mortality rates between hospitals that use only CRNAs compared to hospitals that use only anesthesiologists**, according to a study led by D. Simonson and published in *Nursing Research* in 2007.
- **Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs**, according to an important new study published in the journal *Anesthesiology*. Reviewing over 15,000 anesthesia records in one leading U.S. hospital, it raises critical issues about Medicare claims compliance in a common and costly model of anesthesia delivery at a time when quality and cost-effectiveness are white-hot healthcare issues at every level.
- A study led by Dr. Michael Pine and published in the *AANA Journal* in 2003 concluded that **“Patients are just as safe receiving their anesthesia care from CRNAs or anesthesiologists working individually as from CRNAs and anesthesiologists working together.”**

CRNA Recommendations:

- Amend the language in the Nurse Practice Act in regards to the practice of CRNAs, podiatrists and dentists.
- Become recognized as a type of APN in the Indiana Nurse Practice Act.
- Continue to educate state legislators, nursing organizations, hospital systems and other healthcare professionals about CRNAs’ profession and scope of practice.
- Continue being an active participant in the new Affordable Healthcare Act and its implementation at state and national levels.
- Repeal the federal Medicare physician supervision requirement for nurse anesthetists to allow healthcare facilities nationwide to make their own decisions about how best to staff their anesthesia departments based on state laws and patients’ needs. This will help address current and future patient access issues. Moreover, it will help create the kind of transformational change in the healthcare system called for in the IOM report.
- Remain involved in issues affecting the national and local practice of CRNAs i.e., critical drug shortages, provider nondiscrimination laws, funding for nursing workforce development, patient access to high-quality and cost-effective healthcare, stabilization of Medicare Part B payments and healthcare reimbursement systems.
- Support the establishment of a Nurse Anesthesia Educational Program in Indiana in preparation for the predicted anesthesia provider shortages through 2020 and beyond.

Certified Nurse Midwives (CNMs)

A Certified Nurse Midwife is a registered nurse who has graduated from a nurse midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and has passed a national certification examination to receive the professional designation of certified nurse-midwife. *Certified midwives* are individuals who have or receive a background in a health related field other than nursing and graduate from a midwifery education program accredited by ACME. Graduates of an ACME-accredited midwifery education program take the same national certification examination as CNMs but receive the professional designation of certified midwife. Approximately 82% of CNMs have a master's degree. The American College of Nurse Midwives (ACNM) is the professional association that represents both certified nurse-midwives (CNMs) and certified midwives (CMs) (Fullerton, Schuiling, & Sipe, 2010).

Scope of Practice: Nurse-midwives have been practicing in the United States since the 1920s. CNMs provide primary health care for women across the lifespan from adolescence beyond menopause, with special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. Midwives perform comprehensive physical exams, prescribe medications including contraceptive methods, treatment of male partners for sexually transmitted infections, care of the normal newborn during the first 28 days of life, order laboratory and other diagnostic tests, and provide health and wellness education and counseling (<http://www.midwife.org>).

Licensing/Certification: CNMs are licensed, independent health care providers with prescriptive authority in all 50 states, the District of Columbia, American Samoa, Guam and Puerto Rico (<http://www.midwife.org>). Nurse-midwifery practice in the state of Indiana is governed by the Indiana State Board of Nursing and is protected by the Indiana Nurse Practice Act. CNMs in Indiana possess a special nurse midwife license. For those CNMs who prescribe medications, prescriptive authority is granted by the BON. A documented collaborative agreement must be on file with the BON, that stipulates the manner in which the CNM and the MD will collaborate, and any limitations on the CNMs prescriptive authority. The collaborative agreement must specify a review with the collaborating MD of a random sampling of 5% of the CNMs charts and medications prescribed within seven days of the patient visit. Nurse Midwives must pass a national certification examination with the American Midwifery Certification Board affiliated with the American College of Nurse Midwives prior to practicing.

Serving Society: According to the American Midwifery Certification Board, there are 11,546 CNMs/CMs practicing in the United States (Martin et al., 2010). In 2008, the number of CNM/CM attended births reached a record high of 317,626 as compared to 4.3 million births per year in the US (Childbirth Connection, 2009). This represents 93.9% of all midwife-attended births, 11.1% of all vaginal births and 7.5% of all births. \$86 billion was used for maternal newborn hospital charges in 2006, far exceeding any other condition. Private insurers paid for 49% of the births, while Medicaid covered 43% (Childbirth Connections, 2009). CNMs provide the majority of care to Medicaid recipients. CNM/CM attended births reflect the diversity of the US population. In 2008, CNM/CM attended hospital births were most frequent among American Indian/Alaska Native women (16.9%), followed by Hispanic women (8.1%), non-Hispanic white women (7.0%), non-Hispanic Black women (6.8%), and Asian or Pacific Islander women

(5.9%).(Childbirth Connections, 2009) Additionally, 96.1% of CNM/CM attended births occurred in hospitals, 2.1% occurred in freestanding birth centers, and 1.7% occurred in homes(www.midwife.org/ACNM). More than 50% of CNMs/CMs list physician practices or hospitals/medical centers as their principal employers (Fullerton, Schuiling, & Sipe, 2010). While midwives are well-known for attending births, in 2008, 53% of CNMs/CMs identified reproductive care and 33.1% identified primary care as main responsibilities (Fullerton, Schuiling, & Sipe, 2010). CNMs are defined as primary care providers under federal law.

Indiana: The first midwifery practice in Indiana was established in the 1970s in Lawrenceburg. CNMs in Indiana practice in a variety of settings including hospitals, private practices, birth centers, and home birth practices. Currently, there are approximately 84 CNMs with 70 nurse midwifery service sites throughout Indiana. In 2009, there were 5,666 CNM-attended births, which was 6.54% of all births that year.

Quality/Safety/Economic Value: A meta-analysis published 2011 in *Nursing Economic\$* extending over 18 years compared care provided by advanced practice registered nurses (APNs) to care provided by physicians. This review demonstrates overwhelming evidence of high, quality care of certified nurse-midwives. The categories in which Certified Nurse-Midwives outperformed physicians included:

- lower C-section rates
- fewer epidurals
- less analgesia
- better breastfeeding rates
- more VBACs (vaginal births after delivery)
- fewer NICU admissions
- fewer episiotomies
- fewer perineal lacerations after delivery
- lower rate of labor induction and augmentation

Further evidence of the quality, safety and economic value of nurse-midwives was published in the June 2003 edition of *American Journal of Public Health*. This study funded by the US Agency for Health Care Research and Quality demonstrated that low-risk patients receiving collaborative midwifery care had birth success rates comparable to those who saw only physicians, with fewer interventions, more options, and lower cost to the health care system. Concurrent comparison groups totaling 2,957 women revealed that mothers receiving collaborative/birth center/midwifery care found the same positive outcomes as the 2011 Nursing Economics study as well as the following:

- Decreased time in the birth center or hospital
- Fewer vacuum or forceps assisted vaginal births
- Less technical intervention
- Received more services from the California Comprehensive Perinatal Program

Reimbursement: Equitable reimbursement for midwifery services was addressed in Section 3114 of the Patient Protection and Affordable Care Act by correcting long, standing reimbursement disparities for midwifery services under the Medicare program. The provision ensures that women will have greater access to the essential maternity and primary care services

provided by certified nurse-midwives. The provision mandated payment rates for certified nurse-midwives for covered professional services under Medicaid Part B to be increased from 65% of the fee schedule to 100%, equal to what a physician bills for identical services. This improved access for certified nurse midwifery services was implemented and enforced by The US Department of Health and Human Services Center for Medicare and Medicaid Services effective January 1, 2011. (Patient Protection and Affordable Care Act, S.3590, 111th Congress, 2nd Session 2010)

- The new legislation remedies persistent reimbursement inequalities in the profession. However, state Medicaid plans and third-party payers have not chosen to follow the Medicare lead, leaving certified nurse-midwives at economic peril. CNMs, as APNs, are currently reimbursed by Medicaid fee-for-services at 75% of the physician schedule in Indiana. This rate is set forth in regulation: “Reimbursement for services provided by independently practicing respiratory therapists and advanced practice nurses shall be equal to seventy-five percent of the physician and LLP fees for that service....” 405 Ind. Admin. Code 1-11.5-2.
- Often CNM services may be billed under the physician at institutions where a physician is present; some believe that these arrangements are needed in order that some practices may be economically viable. However, these arrangements serve to render-the services of the CNMs invisible when many quality audits are based on the work of the billing provider (Patient Protection and Affordable Care Act, S.3590, 111th Congress, 2nd Session 2010).
- Although CNMs receive reimbursement through Medicaid and several other health plans, third party reimbursement for their services is not mandated in Indiana thus limiting access to these safe, cost effective services.

CNM Recommendations:

- Implement the consensus Model for APRN regulation: License APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision (APRN Consensus Work Group, 2008). This would permit all CNMs to have prescriptive authority without being dependent on a collaborating physician.
- Mandate that qualified nurse midwives have the right to admit patients to the hospital. Current regulations do not provide protection against hospital governing board decisions that prevent nurse-midwives from admitting their own patients to the hospital even if the CNMs are credentialed allied health staff.
- Allow CNMs to collaboratively manage higher risk pregnancies with a physician colleague according to their education and credentialing and be paid equitable rates by state Office of Medicaid Policy and Planning (OMPP).
- Mandate that CNMs receive 100% reimbursement for Medicaid services in parallel to federal reimbursement regulations.
- Work with the Department of Insurance to develop a more equitable allocation of risk for APN groups especially CNMs based on the number of compensated claims (true risk).
- Develop strategies to educate health insurance companies on the economic value of nurse midwifery care.
- Equitable reimbursement for birthing services regardless of site (hospital vs nonhospital)

- Include APNs in the same incentive payment program as physicians to receive an additional 10% of payment amount for primary care services furnished from January 1, 2011 to December 31, 2015.

Clinical Nurse Specialist (CNS)

Clinical Nurse Specialists (CNS) are licensed registered nurses who have graduate preparation (Master's or Doctorate) in nursing as a Clinical Nurse Specialist (NACNS, 2004). Clinical Nurse Specialists practice in a specialized area of nursing as expert clinicians. The specialty may be identified in the following terms:

- Population (e.g. pediatrics, geriatrics, women's health)
- Setting (e.g. critical care, emergency room)
- Disease or Medical Subspecialty (e.g. diabetes, oncology)
- Type of Care (e.g. psychiatric, rehabilitation)
- Type of Problem (e.g. pain, wounds, stress) (NACNS, 2004)

There are well over 40 specialty areas of practice for the CNS, which developed over time. These specialty areas developed to meet society's need for expert/specialty nursing care. The CNS is a clinical expert within a specialty area of nursing practice.

Scope of Practice: CNSs are recognized as Advance Practice Registered Nurses (APNs) in the state of Indiana. They are licensed as registered nurses in Indiana and have been providing expert nursing care/services to the public for over 50 years within the scope of practice authorized by the Registered Nurse license. There are some CNSs in Indiana who have obtained prescriptive authority. Currently, there is no accurate workforce data for CNSs in the state or at a national level.

Licensing/Certification: Clinical Nurse Specialists in the state of Indiana practice under their RN license. For those CNSs who choose to prescribe medical therapeutics and pharmacological agents, prescriptive authority is granted by stipulations set forth by the Indiana Board of Nursing (BON). A documented collaborative agreement must be on file with the BON, that stipulates the manner in which the CNS and the MD will collaborate, and any limitations on the CNSs prescriptive authority. The collaborative agreement must specify a review with the collaborating MD of a random sampling of 5% of the CNSs charts and medications prescribed within seven days of the patient visit. National certification is not required by statute in Indiana for Advanced Practice Nurses.

Indiana: In Indiana, CNSs are practitioners that provide evidence-based care in a variety of settings. These settings include but are not limited to the following: hospitals, rehabilitation facilities, outpatient offices, private clinics, and nursing homes, correctional facilities, and schools. CNSs continue to meet the needs of the public by increasing their access to community-based care through the expansion of Nurse Managed Health Care Centers. Clinical Nurse Specialists improve the clinical outcomes of populations and groups through leadership and mentoring of nurses and nursing for innovative, evidence-based, quality nursing care. CNSs educate and train the Nursing Workforce in all practice settings. They are viewed as highly

valuable APNs that can be engaged for expert consultation by the nursing staff, medical staff, and other health care providers.

Quality/Safety/Economic Value: The CNS practice integrates nursing practice, which focuses on assisting patients in the prevention or resolution of illness, with medical diagnosis and treatment of disease, injury and disability. CNSs have a unique, high value contribution to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing (NACNS, 2012).

The CNSs are leaders of change within organizations as the clinical experts. They facilitate quality of care in numerous ways, evidence-based programs to prevent avoidable complications, improve the quality of care, improve the safety, prevent hospital readmissions, reduced length of stay, increased patient satisfaction, improved pain management practices, and improve patient outcomes (NACNS, 2012, Dejong, 2004; Murray & Goodyear-Bruch, 2007; Naylor, Campbell et al., 2004; Ryan, 2009; Vollman, 2006). Dejong et al. (2004) study “investigated the effectiveness of a CNS-led community based chronic obstructive pulmonary disease screening and intervention program. The results indicated that of the subjects contacted after the screening, 47% indicated that they stopped smoking, were in the process of quitting, or were seriously considering quitting. In a study by Murray and Goodyear-Bruch (2007) a ventilator associated pneumonia (VAP) prevention program was developed by CNSs and resulted in a reduction in incidence of VAP in the critical care units of a hospital system, with two units having no cases of VAP over a two year period” (NACNS, 2012).

Vollman (2006) looked at pressure ulcer prevalence among vulnerable intensive care patients. Critically ill patients often experience complications including ventilator-associated pneumonia and pressure ulcers. This CNS team found that a CNS directed program reduced pressure ulcer prevalence among vulnerable intensive care patients from 50-80%. CNSs are the coaches that provide transitional care of patient populations with chronic diseases with a goal of preventing readmissions and improving patient outcomes (Naylor et al., 2004; Ryan, 2009). Naylor et al. (2004) “conducted a randomized, controlled trial and found that APRN directed discharge planning and a home follow-up protocol resulted in: fewer readmissions, lower mean total costs, and short-term improvements in quality of life and patient satisfaction” (NACNS, 2012).

Another study completed by Ryan et al. (2009) looked at hospital readmissions, since these are expensive and have a significant impact on a patient’s quality of life. “This study investigated the effectiveness of an evidence-based group discharge education program for patients with heart failure and their families. The results showed that a team of CNSs, a nurse manager, and nursing staff helped reduce hospital readmissions” (NACNS, 2012).

CNSs have been instrumental in improving quality and safety of care and reducing health care costs. The CNS implements evidence-based system wide changes to reduce infections, reduce hospital-acquired conditions, reduce medical errors and reduction of costs in acute care facilities (Murray & Goodyear-Bruch, 2007; Vollman, 2006). CNSs continue to provide value-based services to organizations.

CNSs increase the availability of effective care for those with chronic illness. They are effective coaches, transitional coaches, etc. in promoting self-care and reducing the overall costs related to chronic illnesses. There are several studies that document this care to the chronically ill population, which includes asthma, heart failure, chronic pulmonary disease, and epilepsy (DeJong & Veltman, 2004; Naylor, Campbell, et al., 2004; Ryan, 2009; Vollman, 2006). CNSs improve access to wellness and preventative care to populations at risk for chronic diseases, such as diabetes and heart failure. There are wellness companies that are managed and owned by CNSs. These companies provide ongoing care to keep employees healthy. By engaging CNS managed wellness companies to their employees, employers can expect a decrease in overall health care costs.

Research about Clinical Nurse Specialist practice demonstrates outcomes such as:

- Reduced Hospital Costs and Length of Stay
- Reduced Frequency of Emergency Room Visits
- Improved Pain Management Practices
- Increased Patient Satisfaction with Nursing Care
- Reduced Medical Complications in Hospitalized Patients (NACNS, 2012)

CNS Reimbursement: Currently, there is no reimbursement for CNSs that are employed at hospital based organizations. There is restricted reimbursement for those CNSs that run wellness, preventative care, community based programs, provide mental health services and primary care which is 85% of the physician fee schedule.

CNS Recommendations:

- Eliminate requirements for CNSs with physician “collaborative practice agreements”.
- Remove prescribing restrictions or limitations imposed by required physician oversight, collaboration or signature.
- Amend requirements for hospital participation in the Medicare program to ensure that CNSs are eligible for clinical privileges, admitting privileges, and membership on medical staff.
- Advocate for all insurers, including but not limited to Medicare, Medicaid, and third party insurers, to include coverage of CNS services that are within their scope of practice under state law.
- Amend the Medicare and Medicaid programs to authorize CNSs to perform admission assessments, certify patients for home health care services, and to admit patients to hospitals, hospice and skilled nursing facilities (NACNS, 2012).

Nurse Practitioners (NP)

Nurse Practitioners are registered nurses who are licensed independent practitioners, prepared through advanced graduate education and who practice in ambulatory, acute, inpatient, and long term care settings as primary care and/or specialty providers. Entry-level education for NP practice is at the master’s, post-master’s, or doctoral level. Nurse practitioners practice autonomously and in collaboration with other health care professionals and other individuals to

assess, diagnose, treat, and manage the patient's health care and wellness needs (AANP scope of practice).

Scope of Practice: The NP scope of practice blends nursing and medical services. NPs order, conduct, and interpret diagnostic tests, perform procedures appropriate to their area of expertise, prescribe pharmacologic and non pharmacologic treatments, provide expert education to patients, families, and groups, and lead teams of healthcare providers in a variety of settings. In Indiana, Nurse Practitioners work in collaboration with physicians, in a relationship that can be on-site, or remote. Nurse Practitioners in Indiana can prescribe the entire spectrum of scheduled pharmacologic therapies (Schedule 11-V) with few restrictions.

Licensing and Certification: Nurse Practitioners in the state of Indiana practice under their RN license. For those NPs who prescribe medications, prescriptive authority is granted by the BON. A documented collaborative agreement must be on file with the BON, that stipulates the manner in which the NP and the MD will collaborate, and any limitations on the NPs prescriptive authority. The collaborative agreement must specify a review with the collaborating MD, a random sampling of 5% of the NP charts in which medications are prescribed within seven days of the patient visit. National certification is not required by statute in Indiana for Advanced Practice Nurses. However, Medicare and most health insurance companies require national certification for credentialing and reimbursement. In order to maintain prescriptive authority in Indiana, NPs must obtain a number of continuing education credits that parallels the requirements for the national certifying bodies for NPs.

Serving Society: In Indiana, there are 3,269 Advanced Practice Nurses with prescriptive authority. It is estimated that there are more than 158,000 NPs in the United States, and that 80% work in primary care (Family, Adult, Gerontological, Pediatrics). Eighteen percent of NPs practice in communities of fewer than 25,000 residents. In states with the most favorable practice environments these percentages are much higher (39%-56%). The majority of primary care NPs report treating patients between the ages of 66-85. Over 88% of ANPs accept Medicare patients, and over 80% of FNPs and ANPs accept Medicaid patients. Almost 60% of these NPs also accept charitable or uncompensated patients. Eighty-nine percent (89%) of Pediatric Nurse Practitioners (PNPs) treat children with Medicaid. (AANP paper NPs in Primary Care). Detailed NP workforce data for Indiana is not available. However, the NP is by far the largest of all the APN roles. NPs practice in a variety of settings including hospitals, skilled care facilities, private practices, urgent care, retail health care, occupational and employee health, work based clinics and wellness programs, primary and secondary school based health, university student health, public health, and community based nurse managed health care centers.

Quality/Safety/Economic Value: The NP role was created in 1965, and since that time the preponderance of studies have consistently demonstrated that NP care is equal to or better than that of physicians in a variety of measures. NPs have been found to take better patient histories, thus avoiding unnecessary invasive diagnostic procedures (Avorn, Everitt, & Baker, 1991), they have been found to perform better on quality measures for adhering to ADA guidelines in the management of diabetic patients (Ohman-Strickland, Orzano, Hudson, Solberg, & Diccio-Bloom, 2008), their patients in long term care facilities are less likely to have geriatric

syndromes such as falls, UTIs, and pressure sores (Bakerjian, 2008). NPs were found to have better outcomes in managing hypertensive patients (Mundinger, Kane, Lenz, Totten, Tsai, & Cleary, 2000), and were found to have higher patient satisfaction ratings than physicians (Laurant et al., 2006).

Starting in 1981, the cost of care when NPs are involved has been extensively studied. Labor cost savings ensue when an NP joins a practice, as the mean salary for NPs in today's economy is 50% that of a primary care physician. NPs are not only less expensive providers, they also practice less expensively. A study comparing NP managed practices with MD managed practices in Tennessee, found that NPs delivered care at 23% below the average cost of other primary care providers. This was accounted for by a 21% reduction in hospitalization rates, 24% lower lab utilization, and in another similar study 43% of the ER visits in a matched MD practice, 33% of inpatient days, and total annualized costs per patient that were 50% that of the physician practice (Spitzer, 1997). "Evidence supports using NPs as one of the most cost effective and feasible reforms to solve America's serious problems of cost, quality, and access to health care. The issue is not raising the income of nurse practitioners to the level of physicians in areas where their competencies overlap. Rather, the issue is allowing patients to receive all the clinical and economic benefits of direct access to nurse practitioners." (Bauer, 2010)

NP Reimbursement: Only 31 states mandate payment by private insurers for nurse practitioner services (Chapman, 2010). Among those states the conditions of reimbursement and the amount of payment varies widely. Currently there is limited workforce and reimbursement data on nurse practitioners in Indiana.

Medicare reimburses for NP services, at a reduced rate of 85% of the physician rate (Chapman, 2010). There is a loophole of 'incident to' billing that brings in 100% of the physician rate, which is extremely limited in its applicability to full NP scope of practice. For example, a physician must be present in the office suite when the NP sees the patient, the problems treated by the NP must have been previously diagnosed by the physician, and the physician must see the patient at a frequency that reflects the physician's ongoing management of the patient's care (CMS, 2009). These requirements, describe a greatly limited scope of practice that pertains to the actual practice of very few NPs. 'Incident to' billing is applied by individual health care systems and practices in their desire to reap the maximum reimbursement, despite the risk Medicare fraud.

Medicaid, a federal-state collaboration, has both federal rules and state regulations. Although federal law allows for reimbursement of NPs at a range of 75-100% of the physician rate, (Chapman, 2010), Medicaid waivers are commonly granted to states which design programs that can restrict or limit access to NP services, as is the case in Indiana.

In the mid 1990s Indiana was one of a handful of states to enact 'any willing provider' laws. In the era of newly burgeoning HMOs, these laws were developed to require managed care plans to accept any qualified provider who is willing to accept the terms and conditions of the managed care plan (Hellinger, 1995). The applicable Indiana statute (IC 27-8-11-2) refers to a provider as 'an individual or entity duly licensed or legally authorized to provide health care services'. This would seem to open the door to mandating reimbursement for NP services, however these laws are rarely enforced (Chapman, 2010).

The most conspicuous example of a barrier to health care in Indiana because of reimbursement problems is the structure of the Children's Health Insurance Program (CHIP) program and the low cost Indiana health plan- Healthy Indiana Plan (HIP) program. These programs have severe shortages of providers both in rural areas and in less desirable urban areas. Physician panels are full, there are long waiting lists and patients are often assigned to physicians who are geographically distant from them. There are close to 3,000 willing providers, Nurse Practitioners, who are unable to serve these patients because these state programs do not allow them to be primary care providers and carry panels of patients.

A coherent discussion of private health insurance plans is extremely difficult. Private plans are generally speaking contracts between employers and insurers. The Affordable Care Act seeks to create mandates regarding what healthcare services must be offered through private insurance plans, and who they must cover. By design, NPs are recognized as qualified healthcare providers in the ACO legislation. However, patients cared for by NPs are excluded from participating in the ACO quality measurement and bonus reimbursement. The law specifically states that only the patients of physicians can participate. Additionally, some insurance companies will negotiate a health plan with one employer, and a completely different one with another. Some private insurers credential NPs, some don't. Very often, NPs are providing services, and then billing using a collaborating MD's billing information. This practice just furthers the invisibility of NPs, as it makes data about quality of care, relative cost, and outcomes of NP managed patients impossible to collect.

As more aspects of the Affordable Care Act become operational, bringing more people into the healthcare system, the demand for primary care providers should drive needed changes in who is qualified to provide services and how they are reimbursed. An obvious starting point in Indiana is a concerted legislative effort to include Nurse Practitioners as primary care providers under our CHIP and HIP programs. NPs have demonstrated the skills needed to lead "health care homes". Also, as there are at this time a limited number of healthcare systems vying to be Accountable Care Organizations in the state, it is imperative to create alliances with the leaders of these ACOs to press the case for utilizing NPs in the way envisioned by the 2010 IOM report. Advanced Practice Nurses who have worked collaboratively for their entire careers are uniquely positioned to help lead health care reform.

NP Recommendations:

- Eliminate the collaborative agreement between NPs and MDs.
- Negotiate equitable reimbursement of 100% of the physician fee schedule for same services provided by NPs.
- Enforce the 'any willing provider laws' to mandate insurance reimbursement for NP services.
- Remove barriers in Indiana to identifying NPs as primary care providers who can manage panels of patients in all Medicaid programs, including Hoosier Healthwise, HIP, as well as in all traditional health insurances.
- Remove any statutory language that is not provider neutral from state and federal laws and regulations involving healthcare.

Final Recommendations: APN Reimbursement and Scope of Practice in Indiana

Improving the efficiency and cost effectiveness in the delivery of care is central to real health care reform. As this reform evolves APNs will continue to demonstrate cost effective health care using evidence-based practice principles that produce quality services. Research indisputably supports that economic and clinical gains can be realized by utilizing APNs as independent health care providers and delivery team leaders for a large number of health care services in a variety of settings (Bauer, 2010). Removing APN practice barriers will set the stage for accessible, cost effective and quality health care for the citizens of Indiana. While each APN role has specific recommendations for removing practice barriers, the following recommendations are those most critical for APNs in Indiana.

- Reform Scope of Practice Laws and regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. (Support the Consensus Model for APRN Regulation; License APRN's as independent practitioners (full practice autonomy) with no regulatory requirements for collaboration, direction or supervision.
- Negotiate equitable reimbursement-Receive 100% of the Physician Fee Schedule (PFS) under Medicare for all APNs, as this will set the standard of reimbursement rates and sets a precedent to contest unequal reimbursement rates across specialties which provide similar services.
- Enforce the 'any willing provider laws' to mandate insurance reimbursement for APN services.
- Include APNs in an incentive payment program to receive an additional 10% of payment amount for primary care services furnished from January 1, 2011 to December 31, 2015.
- Remove any barriers that would restrict APNs ability to participate in pay-for-performance initiatives.
- Remove barriers in Indiana to identifying APNs (CNM, CNS, NP) as primary care providers who can manage panels of patients in all Health Insurance Programs especially Medicare and Medicaid programs, including Hoosier Healthwise and HIP.
- Remove any statutory language that is not provider neutral from state and federal laws and regulations involving healthcare.
- Support efforts to allow APNs to have admitting privileges and to be eligible to be on the medical staff.
- Identify state regulations related to advanced practice nursing that have an anticompetitive effect without contributing to the health and safety of the public, and work to change these policies.

- Develop APN sensitive quality measures (indicators) similar to NDNQI (ANA).
- Educate hospitals, insurance providers on the quality and economic value of APN services.

Resources

AANP paper NPs in Primary Care

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