



PENNSYLVANIA COALITION OF
NURSE PRACTITIONERS

KEYSTONES OF QUALITY HEALTHCARE

Improving Access to Healthcare in Pennsylvania:
Full Utilization of Certified Registered Nurse Practitioners

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Introduction

The Pennsylvania Coalition of Nurse Practitioners (PCNP) is an organization representing the interests of over 7,000 Certified Registered Nurse Practitioners (CRNPs) in the Commonwealth of Pennsylvania. PCNP is an affiliate member of the American Academy of Nurse Practitioners and the American College of Nurse Practitioners. PCNP is dedicated to ensuring that all citizens of the Commonwealth have access to quality, affordable healthcare. To achieve this goal, all government entities must have knowledge of the various healthcare providers that are educated and have the skill sets necessary to provide healthcare and to remove the barriers to practice that prevent some providers from doing so. Licensed healthcare providers in the Commonwealth must be utilized to their full scope of practice in a statutory and regulatory environment that both recognizes and supports full scope of practice and authorizes direct reimbursement for that care.

Background

Nurse practitioners are licensed independent practitioners who provide primary and/or specialty nursing and medical care for diverse populations. They practice in rural, suburban and urban areas and their practice sites include:

- Federally-funded clinics
- Assisted living and personal care homes
- Long-term care settings
- Home care
- Veterans Administration facilities
- Women’s healthcare
- Retail clinics
- Employee health
- College health services
- Rural health/migrant clinic
- Nurse managed centers
- Pediatric offices, clinics and hospitals
- Rehabilitation settings
- Medical offices
- Public health
- Psychiatric facilities
- Pain management clinics
- Education and research
- Hospice/Palliative care
- State health facilities

Nurse practitioners in Pennsylvania practice under rules and regulations established by the Board of Nursing based on the Nurse Practice Act. The statutory definition of a nurse practitioner (NP) in Pennsylvania is:

”CRNP—Certified Registered Nurse Practitioner—A professional nurse licensed in this Commonwealth who is certified by the Board in a specialty and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with a

physician licensed to practice in this Commonwealth and in accordance with the act and this subchapter”(1). Different states use different titles to designate a CRNP. For ease of reading, the acronym NP will be used for nurse practitioner throughout this paper.

Entry-level preparation for NP practice is a graduate degree. While most NP programs currently award master’s degrees and/or post-master’s certificates, an increasing number of NP programs award doctoral degrees. In 2004, The American Association of Colleges of Nursing recommended a shift in preparing all advanced practice nurses, including NPs, to the doctoral level by 2015, with the degree title of Doctor of Nursing Practice (2). Many university programs in PA and around the country have instituted this degree program and thousands of NPs now have the title of Doctor of Nursing Practice (DNP). Currently, Pennsylvania has the highest number of DNP programs in the nation.

Nurse practitioners are nationally certified in their specialty area e.g. family practice, women’s care, adult care, pediatric/neonatal care, psychiatric/mental health care and acute care. They are recognized as expert health care providers who provide complete, accessible, affordable, quality care. Nurse practitioners perform a wide array of clinical services e.g. obtaining medical histories, performing physical examinations, diagnosing and treating acute and chronic diseases (such as injuries, diabetes and high blood pressure), prescribing medications, and providing other health care services. In a review of fifteen studies, the conclusion was that between seventy-five percent and eighty per cent of adult primary care services and up to ninety percent of pediatric primary care services can be performed by nurse practitioners (3).

Research has documented that NPs provide safe, accessible, affordable and quality care to individuals, especially to many of Pennsylvania’s most vulnerable citizens. There are over 30 nurse-managed centers in PA that provide primary health care, health promotion and disease prevention services to clients of all ages who are living in poverty, are uninsured or are members of racial or ethnic minorities. Seven nurse-managed health centers in PA have been successful in achieving federally qualified health center status. This ensures federal funding for health care made available at these centers. Over 200,000 patient encounters occur annually at nurse-managed centers for individuals who would otherwise likely lack access to health care services (4).

Cost Effectiveness

In today’s health care arena, cost effectiveness is a major concern. Cost effective outcomes are the least-expensive ways to elicit the specified effect or service.

Cost-effective analysis clearly supports reversing rules and regulations that prohibit reimbursement to NPs while paying more expensive health professionals for clinical services that achieve similar results. Pennsylvania and the United States are each paying a high price for current policies that prevent NPs from practicing within their full, legally defined scope of practice.

Numerous studies have documented that reduction of health care costs could be realized immediately if reimbursement was expanded to cover care delivered by NPs. Continued reimbursement to only physicians increases the cost of health care. One study of 667 nursing home patients demonstrated a cost-saving reduction in hospital admission when residents' care was managed by NPs (5). Another study revealed that hospital admission rates were cut almost in half when NPs managed the primary care of nursing home residents (6). A Tennessee study found that costs at NP managed practices were twenty-three per cent lower than the costs of care delivered by other primary care providers. Inpatient hospitalization rates, a much more expensive arena for healthcare, were twenty-one per cent lower (7).

In Nurse Managed Health Centers, the average primary care encounter cost for clients is ten per cent less than the primary care offered by physicians and other providers. The average personnel cost for these centers is eleven per cent less than the personnel costs for centers run by physicians and other providers (8). In the Philadelphia region, patients in nurse-managed centers are hospitalized thirty per cent less and utilize emergency room services fifteen per cent less compared to patients seen by other health care providers (9).

Another arena where NPs practice, and cost savings are realized, is in Convenient Care Clinics (CCC) across the nation. Over 1,000 of these have opened and over 3.5 million patients have been treated. The original business model called for utilizing NPs as a way to control costs but CCC owners learned quickly that NPs were the "perfect fit" for this concept of health care delivery. These clinics, open seven days a week with weekend and evening hours, enable consumers to choose a more affordable option to treat routine illnesses, receive vaccinations, and receive health education for follow-up care. Satisfaction scores for care at these clinics generally exceed ninety per cent. Uninsured patients experience significant savings—thirty to forty percent less than physician offices and urgent care centers (typically staffed by physicians) and nearly eighty percent less than emergency rooms (10).

Quality of Care

National research since 1965 has consistently demonstrated that NPs provide high-quality and cost-effective care through a unique approach that results in high levels of patient satisfaction. In a large study of over one million veterans, a majority of the primary care clinic patients surveyed reported that they prefer to see NPs as compared with physicians and physician assistants (11).

Recent studies have shown that patient health outcomes are as good or better when delivered by NPs versus physicians. An internationally respected association, the Cochran Collaboration, recently published a review of literature citing over three dozen objective studies that suggest that patient outcomes are similar between physicians and NPs and also suggests that NPs score better on subjective measures of quality such as patient satisfaction (12). Studies published in peer-reviewed journals show that NPs could be substituted for physicians in a significant portion of medical services, ranging from twenty-five percent in some specialty services to ninety percent in primary care--with at least comparable outcomes. A very significant finding of more than one hundred published reports on the quality of care provided by both NPs and physician demonstrated that “not one single study found that NPs provide inferior services within the overlapping scopes of licensed practice” (13).

The National Practitioners Data Base (NPDB) is a centralized database where a compilation of negative occurrences such as malpractice, adverse actions, state licensure actions and other negative events are compiled. A study done of accumulated malpractice and adverse actions in the NPDB between 1990 and 2008 revealed the following:

- Overall occurrence rates for medical doctors: one in four
- Overall occurrence rates for osteopathic physicians: one in four
- Overall occurrence rates for nurse practitioners: one in 173 (14).

Reimbursement and Enrollment

The Insurance Payment to Registered Nurse Law (1986 P.L. 1737, No 209) passed by Congress in 1986, provided reimbursement for NP services.

Legislation was passed in 1997 that reimburses NPs for services rendered to Medicare recipients with no restriction by site or geographical area. CHAMPUS and the Federal Employee Health Benefits Plan reimburse for services provided by NPs.

Primary and acute care services are well within the NP scope of practice but some insurance companies will not enroll or credential NPs directly but instead do so through a collaborative physician. This is problematic. It is a patient safety issue. Follow-up information for referrals, testing, diagnosis and treatment is delayed because test results may go to the physician instead of to the NP who is the direct care provider to the patient. Provider panels are inaccurate, often listing only the physician(s) and not the NP(s) who may be closer to the patient's home. Access to care may be limited by a specific provider panel because the provider to patient ratio is being calculated on only the physician. This arrangement also inhibits the accurate tracking of provider quality and outcome data as well as cost comparisons.

Pennsylvania gives discretion to commercial insurers with this statement: "a plan may consider a CRNP as a primary care provider if the CRNP meets the plan's credentialing criteria and practices..." (15). Across the Commonwealth, there is a confusing and incongruous interpretation of this. Some Medicaid MCO's in eastern PA reimburse NPs, as do insurers Aetna, United Healthcare and Independence Blue Cross. Yet, the "Blues" in central and western PA will not credential NPs. Some large insurance companies in western PA (e.g., University of Pittsburgh Medical Center (UPMC) insurance plan) will credential NPs as "specialists" rather than primary care providers. This results in a higher co-pay for patients. At times a referral from a primary care provider to the NP is necessary if the patient is insured by a MCO since the NP is designated as a specialist, again increasing the cost of care. Another irony is that the NP is credentialed as a specialist and therefore cannot refer to the appropriate level of care due to this inaccurate designation.

The Commonwealth of Massachusetts recently passed a law mandating carriers to reimburse nurse practitioners. Previously, NPs in MA were authorized by law to act as primary care providers but private insurance companies did not list them on provider panels nor did they directly reimburse NPs. A bill passed in 2008 that compelled all insurance carriers in the Commonwealth of Massachusetts to directly reimburse NPs and to include them on insurance company provider panels corrected this. Enactment of this law resulted in increased access to quality healthcare for the citizens of the Commonwealth of Massachusetts (16).

In a national survey in 2007 of 220 managed care organizations, nearly half of the respondents replied that they refuse to credential NPs as primary care providers. Staff members were asked why the company had this policy. The most commonly stated reason was that NPs must bill under a physician's provider number, which was the carrier's official policy. Others responded that state law did not require it; that NPs were only credentialed in geographical areas where there is a physician shortage or that NPs did not meet the company's criteria for primary care providers (17).

Action By National State Boards of Nursing and Advisory Groups

Advance practice registered nurses (APRNs) include NPs, clinical nurse specialists, nurse anesthetists and nurse midwives. Currently, there is no uniformity across states in defining what an advanced practice registered nurse is, what advanced practice nursing and education encompasses, and licensing and credentialing requirements. The National Council of the State Boards of Nursing (NCSBN) decided that these issues needed to be addressed at the national level. The NCSBN Advanced Practice Registered Nurse (APRN) Committee and 23 nursing organizations met over the course of four years and reached consensus on a model for future APRNs. A landmark document, the APRN Consensus Model, is a collaborative work of the Advanced Practice Registered Nurse Consensus Work Group and the National Council of State Boards of Nursing Advanced Practice Registered Nurse Committees. The model establishes clear expectations for future APRN licensure, certification, education, and accreditation. The document was published in July 2008. The targeted timeline for full implementation of the model is 2015. Adoption of the Consensus Model will decrease duplication of efforts by individual state boards of nursing in areas such as setting education standards. It will also prevent APRNs from being denied a license to practice if he/she moves to another state since education, certification, accreditation, and licensure will be standardized across the nation. It also provides added protection for the public by ensuring that all APRNs are educated broadly with comprehensive preparation to provide care. There are other implications for practice and research that will be achieved when this is fully implemented (18).

In January 2010, the Josiah Macy Foundation, a private philanthropy dedicated to improving the health of individuals and the public via advancing the education and training of health care professionals, assembled a panel of over fifty participants. The interdisciplinary panel included forty-seven physicians, nurses, and physician's assistants from across the nation. Recommendations emanating from this conference addressed

increasing the number of primary care providers, improving reimbursement issues, investing in health information technologies as well as many others. One recommendation, recognizing the need for increased primary care providers, was to have state and national legal, regulatory and reimbursement policies changed to remove barriers that make it difficult for NPs to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery (19).

A similar recommendation was made by the Institute of Medicine in a book published fourteen years earlier in 1996. The committee that was responsible for the content of the book recommended that state governments review current restrictions on the scope of practice for NPs and eliminate or modify restrictions that impede collaborative practice and reduce access to quality primary care (20). Fourteen years later and that recommendation has yet to be implemented in many states.

Yet another initiative was launched in 2008 by the Institute of Medicine (IOM) in collaboration with the Robert Wood Johnson Foundation. The goal of the initiative was to produce a report that would make recommendations to remove barriers faced by the nursing profession and to devise an action-oriented blueprint for the future of nursing. The nursing profession is the largest segment of the health care workforce. One barrier, specific to states, is that the tasks that NPs are permitted to perform are determined NOT by their education and training, BUT by the unique state laws that they work under—specifically citing the physician oversight or collaboration required by many states. The report offers recommendations for a variety of stakeholders—state legislators, the federal government, the insurance industry, businesses, health care organizations, professional organizations, and others (21).

These initiatives have been presented at a critical time in the healthcare arena in America. The recently passed federal Patient Protection and Affordable Care Act of 2010 will add over 32 million currently uninsured people to the health care arena. However, there are not enough primary care physicians now and it is predicted that there will be a shortage of 40,000 family physicians by 2020. The U.S. health care system has about 100,000 family physicians and will need 139,531 in ten years. Currently, only about half that number is pursuing this specialty. The number of U.S. medical school students going into primary care has dropped over fifty-one per cent since 1997 (22). Pennsylvania had about 16,300 primary care providers in 2008 according to the Kaiser Family Health Foundation. This reflects a shortage of 1,000 physicians based on current needs or about seven per cent of this total. That shortage is expected to rise to twenty per cent over the next decade (23).

Nurse practitioners can certainly assist in filling this gap as they have been doing for 45 years. The first NPs were educated at the University of Colorado in 1965. As of 2010, there are about 135,000 NPs practicing in the United States. Close to 8,000 new NPs are prepared each year at over 325 colleges and universities. Ninety-two percent of NPs in the United States maintain national certification (a requirement in PA), thirty-nine per cent have hospital privileges, and over ninety-six per cent prescribe medications and write an average of nineteen prescriptions a day. Nurse practitioners can prescribe medications in all fifty states (24). In Pennsylvania, there are 23 institutions of higher learning, both public and private, that have programs to prepare NPs. There are over 7,000 nurse practitioners certified by the PA Board of Nursing.

Legislative and Regulatory History of Nurse Practitioners in PA

Nurse practitioners have labored for many years to overcome barriers to practice in Pennsylvania. One of the problems contributing to this was that the Board of Medicine (BOM) and the Board of Nursing (BON) dually regulated NPs. This occurred in only eight other states at that time. Rules and regulations for NPs were approved by both the BON and the BOM in 1977. One significant barrier was the interpretation by the Board of Medicine that NPs could not prescribe medications. The rules and regulations developed for NPs stated that NPs could perform acts of medical diagnosis or prescription of medical therapeutic or corrective measures. The Board of Nursing interpreted this to mean that NPs could prescribe medications but the Board of Medicine fought this interpretation for twenty-six years. Prescriptive authority for Pennsylvania NPs was not achieved until 2000.

Act 206, passed in 2002, removed joint oversight of CRNPs by the Board of Medicine and the Board of Nursing. Nurse practitioners were the only professionals in PA regulated by two Boards—Board of Medicine and Board of Nursing. CRNPs are regulated now only by the Board of Nursing.

In 2002, the Department of Health (DOH) began citing hospitals where NPs were writing orders. According to their regulations, only physician, dentists and podiatrists could write orders in hospitals. PCNP representatives met with DOH representatives and testified at hearings regarding the role of NPs in hospital settings. In July 2003, the DOH issued revised interpretation of rules and regulations so that tertiary policy personnel could write guidelines to permit NPs to write orders in hospitals.

Other legislative initiatives included bills to permit NPs to verify a person's claim to have a disability, sign for patients to obtain disability plates and placards, sign school teacher physicals, and sign RESET physical forms for Temporary Assistance to Needy Families (TANF). Some of these passed and others did not. These bills were introduced to replace forms that contain "physician only" signature blocks. Many of the forms were developed before the advent of nurse practitioners and are in statute. It remains a cumbersome and expensive task for the PA Legislature to change the language on myriad forms from different state agencies to include NPs.

Act 48 was passed in 2007 and removed more barriers to NP practice. Nurse practitioners can now order durable medical equipment (although federal regulations do not permit this), sign disability assessments for the program providing TANF, issue home bound schooling certifications, make physical, occupational and respiratory therapy referrals, dietician referrals, and issue oral orders to the extent permitted by the health care facilities' by-laws, rules, regulations or administrative policies and guidelines.

Act 123, passed in the 2009-2010 legislative session, ended the previous statute's dictum that only physicians could sign schoolteacher physicals. The original legislation was passed in the 1940's when nurse practitioners were nonexistent. Nurse practitioners have been able to perform history and physicals since their rules and regulations were established. This is one of many examples of outdated state forms that have to be changed by the statutory process.

Services to Medicaid patients can also be reimbursed but state rules and regulations apply to this. In Pennsylvania, the Department of Public Welfare (DPW) issued a bulletin in December 2005 that Medicaid would credential all NPs as primary care providers BUT managed care organizations (MCOs) could decide whether to enroll NPs as primary care providers. Therefore, patients cannot choose their own health care provider if the MCO chooses not to enroll NPs on their provider panel. In 2006, DPW issued another bulletin stating that nurse practitioners could be primary care providers for the Medicaid Access Plus program. Yet another DPW bulletin, issued in 2010, removed a barrier to practice for NPs. Clients in outpatient psychiatric clinics and outpatient partial hospitalization facilities can now be prescribed medications by NPs.

Action Agenda

Legislators and state agency personnel must continue to work to remove barriers to health care for the citizens of the Commonwealth. Not only would this improve the health of Pennsylvania's vulnerable populations, but it would also save health care dollars.

Highmark recently announced that they will recognize NPs as primary care providers—but only for those NPs who maintain their own private practice. No recognition of primary care provider status is granted to NPs employed by another entity (e.g., physician owned offices, hospitals, hospice, etc.). Many MCOs that have Medicaid contracts (e.g. Gateway and Unison in southcentral PA) will not credential NPs. Medicaid MCO's in eastern PA reimburse NPs, as do insurers Aetna, United Healthcare and Independence Blue Cross. Yet, the “Blues” in central and western PA will not credential NPs. Medicare MCOs will not credential NPs. Some large insurance companies in western PA e.g. University of Pittsburgh Medical Center (UPMC) insurance plan will credential NPs as “specialists” rather than primary care providers. Other third party payers restrict credentialing and empanelment of NPs. Uniformity in credentialing for NPs in the Commonwealth is nonexistent.

The country may be spending up to \$8.75 billion dollars that could be saved by employing NPs and clinical nurse specialists fully (25). How many health care dollars are squandered in Pennsylvania because insurance companies will not credential NPs and put them on their provider panels?

Regulatory Actions

Create meaningful consumer access to nurse practitioners through greater representation as primary care providers in insurance company provider networks.

Credential and empanel NPs directly as reimbursable providers and establish similar requirement and monitoring for contracts with managed care entities operating state-funded programs.

Credential and empanel NPs as reimbursable providers in MCOs and private insurance carriers.

Develop consistent rules and regulations within the Department of Insurance to compel third party payers and insurers that have state contracts to empanel and credential NPs.

Establish mechanisms within appropriate state departments to monitor inclusion of NPs as credentialed providers in managed care organizations, commercial MCO licensed networks and private insurers. Report findings to PCNP and other appropriate agencies semi-annually.

Eliminate barriers to practice that originate in state departments within the Commonwealth.

Forms with “physician only” signature blocks need to be eliminated and replaced with provider-neutral language. Many state departments maintain forms with physician only signature blocks even though many of these forms are completed by NPs and then submitted to a physician for his/her signature.

Improve access to mental health care for Medicaid clients.

Medicare and all commercial insurers recognize and reimburse for the services of psychiatric /mental health NPs. These insurers pay for initial evaluations and medication management. The Pennsylvania Department of Public Welfare (DPW) has a separate designation for “psychiatric evaluation” which only a psychiatrist may conduct. The Department has created a separate, but unequal, designation for initial psychiatric evaluations performed by NPs and physician assistants. There are differences in reimbursement for services provided by psychiatrists and psychiatric NPs in Medicare and a few, but not all, commercial insurance providers. Nurse practitioners are reimbursed at a somewhat lower rate by a few of these entities. However, the difference between psychiatric NP and psychiatrist reimbursement is the highest in the DPW system. Reimbursement rates for psychiatric NPs treating Medicaid clients must be raised to more equitable levels.

There are special programs in the state that are managed by local mental health/mental retardation (MH/MR) programs such as a long-term residential program in York County. The administrators in that system, and perhaps others, do not accept the services of psychiatric/mental health NPs. This is burdensome to outpatient mental health agencies that rely on both physicians and NPs to provide contracted mental health services. Uniformity across county lines needs to be established in state-funded MH/MR programs.

Statutory Actions

End the further creation of unintended barriers in statute by adopting statutory construction language rules that use a more inclusive term than “physician” for legislative intent that means health care professional as authorized by law.

The General Assembly and the Governor’s Office will give direction to and join in partnership with the Legislative Reference Bureau and the Independent Regulatory Review Commission to adopt statutory and regulatory terminology that is inclusive of nurse practitioners.

End statutory requirement for collaboration between physicians and nurse practitioners.

As part of the health care team, NPs always practice in collaboration with numerous team members to provide holistic seamless care to their patients. Current law requires that a nurse practitioner have a collaborative physician and a backup physician. It has been reported to PCNP that some NPs in rural areas cannot find a physician who will collaborate with them, therefore forcing citizens to travel great distances or forego health care altogether. Nurse practitioners are willing and able to work in rural areas, areas that many physicians avoid for various reasons. Nurse practitioners who have their own practice in urban areas many times have to pay a physician to enter into a collaborative relationship so that the NP can establish and maintain a practice. Nurse practitioners in fourteen states have plenary authority, which means that no mandated collaboration is required for NP practice. Maryland recently became the fifteenth state to eliminate this barrier to practice (*See map on pg. 15*). Nurse practitioners can and do refer to other health care providers when they deem it to be necessary but, as stated previously, NPs can provide up to ninety per cent of primary care services.

It is recommended that this requirement for a formal collaborative agreement be ended as it creates an unnecessary barrier to NP services and increases the cost of health care. This is not only the recommendation of PCNP, but also the recommendation of numerous groups that develop health care policy.

Eliminate the inability of nurse practitioners to sign Workman's Compensation physicals.

The likelihood of any time lost from work was lower for patients seen by NPs and the duration of lost work time and medical costs did not differ by provider type (26). Only eighteen states prohibit NPs from signing workers compensation claims (*See map on pg. 16*). This is another example of wasted Commonwealth health care dollars when an NP many times performs the physical but a physician has to sign the form.

Eliminate physician only ability to sign Do Not Resuscitate (DNR) order.

Title 20 (Section 5484) mandates that the attending physician sign such orders. Nurse practitioners are known for establishing a trusting relationship with the patient and his/her family and this often leads to a discussion of end of life decisions. Nurse practitioners provide care to many terminally ill and frail elderly patients and must be given the opportunity to document their end of life wishes in an order—written and signed by these professionals.

End the inability to sign death certificates.

A nurse practitioner can ascertain the death of a patient but is unable to write the cause of death and sign the certificate. Yet, this same NP may have been treating the patient during the time of his/her terminal illness and can certainly determine the cause of death. The original legislation is contained in the Vital Statistics Law (Section 507(d)) and it states that the responsibility for determining the cause of death remains with the physician or the coroner. Some county coroners in the Commonwealth are not physicians and have no medical background. Legislation needs to be introduced to change this outdated statutory language.

Federal Issues

It is not within the purview of the PA legislature and regulatory agencies to pass federal legislation and propose rules and regulations pertaining to those laws. However, it does behoove members of the executive and legislative branches and the regulatory agencies of PA to be knowledgeable regarding federal health care issues. Many of the health care mandates issued by the federal government affect both the health care of PA citizens and the cost to the Commonwealth of providing that care.

Health care for disabled and older Pennsylvanians is paid for primarily through Medicaid and Medicare. Medicaid is operated by the state, but regulated and funded by both the state and federal governments. Not all Medicaid-contracted insurance companies empanel or credential NPs, thus creating barriers to care for Medicaid clients. Medicaid authorizes NPs to perform the initial history and physical on individuals in nursing homes but Medicare requires a physician to do the initial history and physical. Most homes in PA are dually certified for both Medicaid and Medicare. Pennsylvania adopts the Medicare standard in order to streamline provider requirements. The effect of this policy is that it is an unnecessary barrier to Medicaid clients.

Medicare is funded, regulated and operated by the federal government. Medicare recognizes the ability of NPs to provide high quality care to the elderly by authorizing reimbursement for Part B services. However, Medicare regulations prohibit an NP from ordering Home Health Care or Hospice Care. Instead, patients must find a physician to sign for these services when needed at an additional cost due to this regulation. Medicare regulations also require that a physician conduct the initial history and physical for nursing home patients. Another costly regulation created by Medicare is that only physicians can order durable medical equipment.

Federal regulations also preclude NPs from signing federal employees Workman's Compensation forms and forms for loan forgiveness due to disability.

Action

PA legislators, Department of Health officials and Department of Public Welfare officials should strongly encourage the Center for Medicare and Medicaid Services (CMS) to change their regulations so that NPs can:

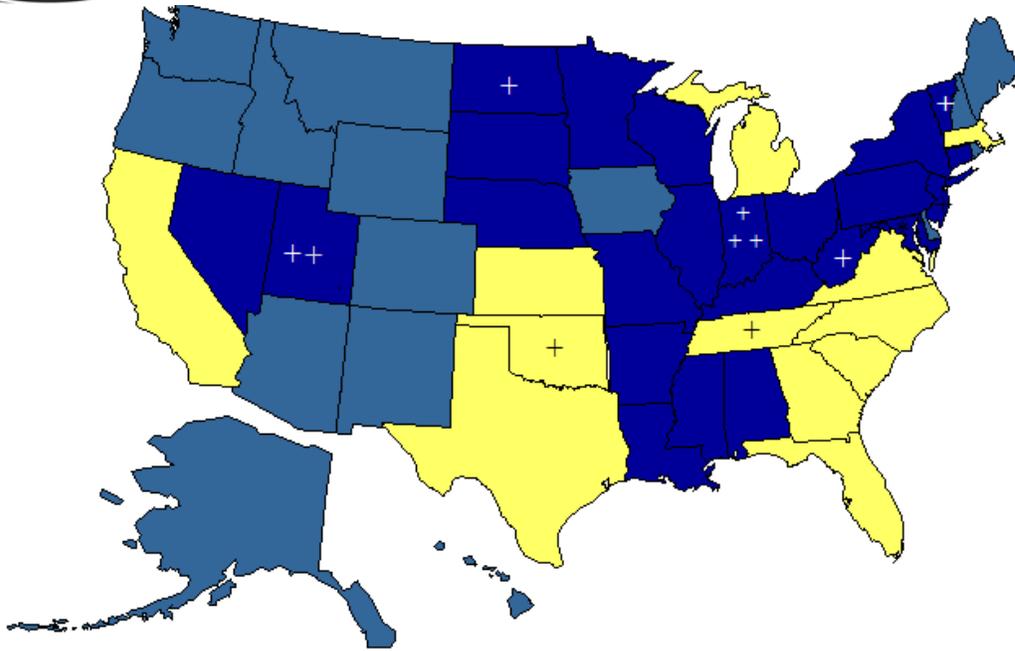
- Perform skilled nursing facility initial patient history and physical
- Order referrals for home health care and hospice care.
- Order durable medical equipment

Conclusion

The background of the problems encountered and the requisite actions to remove barriers to health care for consumers in Pennsylvania and the nation are not insurmountable. As noted, many national and international policy experts and noted health care professionals have provided data that demonstrates that nurse practitioners are educated, skilled, competent providers of health care. Many times, they are the providers of choice for consumers. Actions to remove statutory and regulatory barriers are long overdue. It is up to legislators, regulatory agency personnel, and the executive branch to understand the issues and to diligently pursue the recommendations contained within this paper.



STATE PRACTICE ACTS & REGULATIONS FOR NURSE PRACTITIONERS



- Autonomous Practice/Plenary Authority (No Physician Relationship Required)
- Collaboration with Physician
- General Supervision/Delegation by Physician
- + Collaboration or Supervision for Prescribing Only
- ++ Collaboration for Prescribing Schedule II Drugs Only
- +++ Other

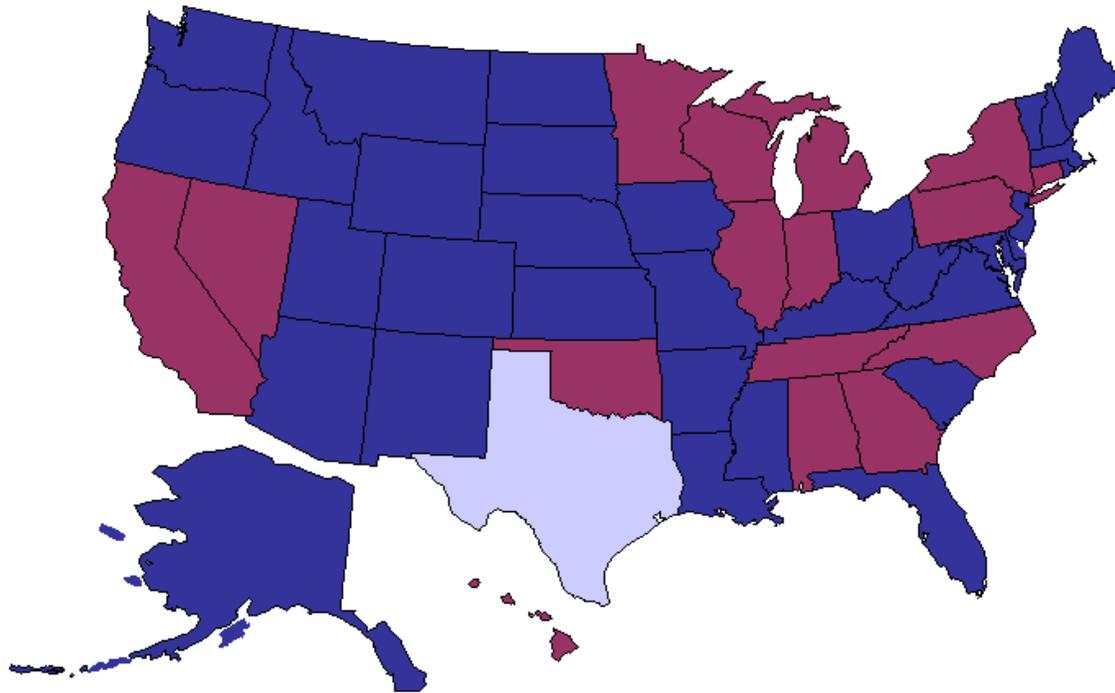
Source: State Nurse State Practice Acts
and Administration Rules, 2009
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The American Academy of Nurse Practitioners is the largest full service Nurse Practitioner organization representing the 135,000 Nurse Practitioners in all Specialties

Update: 6/11/10



NURSE PRACTITIONER AUTHORITY TO SIGN WORKERS COMPENSATION CLAIMS



- States Where Nurse Practitioner Can Sign Workers Compensation Forms
- States Where Nurse Practitioner Can Not Sign Workers Compensation
- Can sign if Delegated by Physician

Source: State Nurse State Practice Acts
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Endnotes

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