REIMBURSEMENT OF RURAL CLINICS UNDER MEDICARE AND MEDICADE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

H.R. 8543, H.R. 791, H.R. 8459, H.R. 6259, and H.R. 2504

[similar bills]

TO AMEND TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT TO PROVIDE PAYMENT FOR RURAL HEALTH CLINIC SERVICES, AND FOR OTHER PURPOSES

AND

H.R. 8422

[as reported by the Ways and Means Committee]

A BILL TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE PAYMENT FOR RURAL HEALTH CLINIC SERVICES

JULY 29, 1977

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REIMBURSEMENT OF RURAL CLINICS UNDER MEDICARE AND MEDICAID

FRIDAY, JULY 29, 1977

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 9 a.m., pursuant to notice, in room 2359, Rayburn House Office Building, Hon. James J. Florio presiding [Hon. Paul G. Rogers, chairman].

Mr. FLORIO. Ladies and gentlemen, the hearing will come to order.

Chairman Rogers, I believe, is in the Clean Air Conference Committee; therefore he has asked me to convene the meeting, to submit the opening statement, and preside over the hearings this morning. This is the statement of Mr. Rogers with regard to the legislation amending the Social Security Act to provide payment for rural health clinic services.

This morning the subcommittee will hear testimony on several legislative proposals designed to provide reimbursement under the medicare and medicaid programs for services provided in rural health clinics. We will be particularly interested in learning of the need for reimbursing such clinics under medicaid, as well as any potential problems associated with it.

Several characteristics of communities in rural America create difficulties for the delivery of primary care services. Those communities are usually small, sparsely populated, and relatively isolated geographically from major metropolitan areas. In recent years many of these communities have lost their physicians, who were their only providers of health services. In other communities, small towns and cities there simply are not enough physicians or other health providers to provide adequate access to all citizens of that area. The Department of Health, Education, and Welfare estimates that approximately 31.6 million Americans live in small towns and rural areas which are designated as "medically underserved."

The citizens and health providers from these rural areas, however, have not been passive. They are to be commended for aggressively and imaginatively addressing their lack of health services. Of the 3,400 rural medically underserved areas, over 500 are now served by health clinics. These clinics are staffed by nurse practitioners and physician assistants who work with physicians either directly or by consultation and written medical protocol.

The same characteristics which prompted the development of these clinics would not alleviate their ability to become financially self-sufficient. It appears that our present reimbursement system, which

does not reimburse nurse practitioners and physician assistants, may not provide adequate reimbursement for services rendered by these clinics. If not, medicare and medicaid beneficiaries in rural America may not have financial access to the health care services which are available to them.

I have a statement from Congressmen Tim Lee Carter, who is also at the Clean Air Conference, and without objection I shall read it into the record at this time.

"Mr. Chairman, I would like to welcome all of our witnesses here this morning, and stress once again that I share your concerns about the problems of rural health care in this country.

"The legislation that we are going to consider here today is significant, in that it will provide basic rural health clinic services to needy citizens, both young and old.

"The bill also sets up a reimbursement procedure which can be both efficient and effective.

"One other very important aspect of this proposal, is that it promotes a collaboration, that is long overdue, among various health professionals. We have seen this kind of cooperative effort at work in Kentucky for 50 years at the Frontier Nursing Service, and the result has been a significantly healthier rural population.

"Mr. Chairman, as a Congressman, I want to encourage and aid our States to help us achieve the purposes of this legislation. And as a physician, I must strongly urge the kind of cooperation among health practitioners that will improve the delivery of care in underserved areas, and will bring us to the ultimate goal of better health for all our citizens."

Also without objection the text of H.R. 8543, H.R. 791, H.R. 8459, H.R. 6259, H.R. 2504, and H.R. 8422 (as reported from the Ways and Means Committee)—bills to be considered by the subcommittee—and agency reports on H.R. 791 and H.R. 2504 will be printed at this point in the record.

[Testimony resumes on p. 45.]

[The bills and agency reports referred to follow:]

95TH CONGRESS
1ST SESSION

H. R. 8543

IN THE HOUSE OF REPRESENTATIVES

JULY 26, 1977

Mr. ROGERS (for himself, Mr. CARTER, Mr. PREYER, Mr. SCHEUER, Mr. FLORIO, Mr. MAGUIRE, Mr. MARKEY, Mr. OTTINGER, and Mr. WALGREN) introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Ways and Means

A BILL

To amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1832(a) of the Social Security Act is amended—

(1) by striking out "paragraph (2) (B)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B) and (D) of paragraph (2)"; and

(2) by striking out the period at the end of paragraph (2) (C) and inserting in lieu thereof "; and" and

by adding the following new subparagraph at the end of paragraph (2):

"(D) rural health clinic services.".

(b) Section 1833 (a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (1);

(2) by inserting "(except those services described in subparagraph (D) of section 1832 (a) (2))" in paragraph (2) after "1832 (a) (2)";

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", and"; and

(4) by inserting the following new paragraph after paragraph (2):

"(3) in the case of services described in section 1832 (a) (2) (D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861 (v) (1) (A).".

(c) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Rural Health Clinic Services

"(aa) (1) The term 'rural health clinic services' means—

"(A) physicians' services and such services and

supplies as are covered under section 1861 (s) (2) (A) if furnished as an incident to a physician's professional service, and

"(B) such services furnished by a physician extender and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service,

when furnished to an individual as an outpatient of a rural health clinic.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r) (1)) under which provision is made for the period review by such physicians of covered services furnished by physician extenders, the supervision and guidance by such physicians of physician extenders, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the

availability of such physicians for such referral of patients as is necessary and for advice and assistance in the management of medical emergencies; and in the case of a physician-directed clinic, such clinic has one or more of its staff physicians perform the activities accomplished through such an arrangement;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals meeting the requirements under this title for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has policies, which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more physicians and one or more physician extenders, to govern the services referred to in subparagraph (A) which it provides;

"(F) has a physician or physician extender responsible for the execution of such policies relating to the provision of the clinic's services;

"(G) directly provides routine diagnostic services, including clinical laboratory services as prescribed in regulations by the Secretary, and has prompt access to

additional diagnostic services from facilities meeting requirements under this title;

"(H) has available for administering to patients of the rural health clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements in compliance with State and Federal law for storing, administering, and dispensing any drugs and biologicals; and

"(I) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in a rural area designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount custom-

arily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician extender, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases.

"(3) The term 'physician extender' means, for the purposes of this subsection, a nurse practitioner or physician assistant who performs such services as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(d) Section 1862 (a) (3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861 (aa) (2), and in other cases".

(e) Section 1861 (s) (2) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (C) (ii);

(2) by inserting "and" at the end of subparagraph (D); and

(3) by adding the following new subparagraph at the end thereof:

"(E) rural health clinic services;".

(f) Section 1864(a) of such Act is amended—

(1) by inserting "or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2)," in the first sentence after "home health agency,";

(2) by inserting "rural health clinic," in the second sentence after "nursing facility,"; and

(3) by inserting "rural health clinic," in the last sentence after "facility," each time it appears therein.

(g) The amendments made by this section shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

SEC. 2. (a) Paragraph (2) of section 1905(a) of the Social Security Act is amended to read as follows:

"(2)(A) outpatient hospital services and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other outpatient services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan;".

(b) Section 1905 of such Act is amended by adding after subsection (k) the following new subsection:

"(l) The terms 'rural health clinic services' and 'rural health clinic' have the meanings given such terms in section

1861 (aa), except that clause (ii) of section 1861 (aa) (2) shall not apply to such terms.".

(c) Section 1902 (a) of such Act is amended—

(1) by striking out the semicolon at the end of paragraph (13) and inserting in lieu thereof ", and", and by adding at the end of such paragraph the following new subparagraph:

"(F) for payment of the reasonable cost of services provided by rural health clinics under the plan, which shall not exceed the amount which would be determined under section 1833 (a) (3) as the reasonable cost of such services for purposes of title XVIII;"; and

(2) by inserting "or by reason of the fact that the plan only provides for rural health clinic services only in rural areas" before the semicolon at the end of paragraph (23).

(d) Section 1910 of such Act is amended—

(1) by amending the heading to read as follows: "CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS";

(2) by striking out "(a)" and inserting in lieu thereof "(a) (1)";

(3) by striking out "(b)" and inserting in lieu thereof "(2)"; and

(4) by adding at the end thereof the following new subsection:

"(b) (1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

"(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility which has applied for certification by him as a qualified rural health clinic.".

(e) Section 1866(c)(2) of such Act is amended by striking out "section 1910" and inserting in lieu thereof "section 1910(a)".

(f) The amendments made by this section shall apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the calendar quarter that begins more than six months after the date of enactment of this Act.

SEC. 3. (a) The Secretary shall provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under title XVIII of the Social Security Act and, notwithstanding any other provision of title XVIII, for services provided

by physician extenders employed by such clinics which would otherwise be covered under such title if provided by a physician.

(d) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

(1) the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing physician extenders;

(2) the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics;

(3) the appropriate definition for such clinics;

(4) the appropriate criteria to use for the purposes of designating urban medically underserved areas; and

(5) such other possible changes in the present provisions of title XVIII of the Social Security Act as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this section shall be made in appropriate part from the Federal Hos-

pital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary, giving due regard to the purposes of the demonstration projects.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration projects conducted under subsection (b). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

SEC. 4. (a) The Secretary, directly or through contracts with or grants to public or private agencies or organizations, shall develop and carry out demonstration projects to provide reimbursement under title XVIII for services provided in organized centers offering comprehensive outpatient mental health services.

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(b) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

(1) the relative advantages of various types of reimbursement, including reimbursement on a cost basis for outpatient mental health services;

(2) the relative effects on utilization and cost of services resulting from (A) various definitions for outpatient mental health services covered under title XVIII of the Social Security Act (when provided by a center described in subsection (a)) and (B) various limitations on such services;

(3) the appropriate definition for such a center;

(4) the appropriate definition of and qualification for individuals who provide services in such centers for which reimbursement is made under title XVIII or this section, including their appropriate professional relationships; and

(5) such other changes as might be appropriate for the more efficient and cost-effective reimbursement of outpatient mental health services provided under title XVIII of the Social Security Act.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this sec-

tion shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary, giving due regard to the purposes of the demonstration projects.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration projects conducted under subsection (b). Such report shall include any recommendations for legislative changes in title XVIII of the Social Security Act which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

(e) In the case of any demonstration project under subsection (a), the Secretary may waive compliance with the requirements of title XVIII of the Social Security Act insofar as such requirements relate to methods of payment for services provided; and costs incurred in such project in

excess of those which would otherwise be reimbursed or paid under such title may be reimbursed or paid to the extent that such waiver applies to it (with such excess being borne by the Secretary).

95TH CONGRESS
1ST SESSION

H. R. 791

IN THE HOUSE OF REPRESENTATIVES

JANUARY 4, 1977

Mr. BROYHILL introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend title XVIII of the Social Security Act to authorize payment under the supplementary medical insurance program for services furnished by physician extenders.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1861 (s) (1) of the Social Security Act is amended by inserting immediately before the semicolon at the end thereof the following: "(including physician extender services rendered under the supervision of a physician whether or not such services are rendered in the physician's office or at a place where the physician is physically present)".

I

"Physician Extender

"(aa) The term 'physician extender' means a physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who has successfully completed a program of study approved by the Secretary, or who is holding a valid certificate as a physician assistant issued by the National Commission on Certification of Physician's Assistants or by any qualified successor to the Commission, or who is licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered.".

SEC. 2. The amendments made by the first section of this Act shall apply with respect to services furnished on or after the first day of the month following the month in which this Act is enacted.

95TH CONGRESS
1ST SESSION

H. R. 8459

IN THE HOUSE OF REPRESENTATIVES

JULY 21, 1977

Mr. FLORIO (for himself, Mr. SCHEUER, Mr. WALGREN, Mr. MURPHY of New York, Mr. EILBERG, Ms. OAKAR, Mr. LEGGETT, Mr. VAN DEERLIN, Mr. BEDELL, and Mr. CORNWELL) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title XIX of the Social Security Act to require States to reimburse health facilities on a preestablished all-inclusive rate for comprehensive routine maternity services provided by nurse-midwives.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

FINDINGS AND PURPOSE

SECTION 1. (a) Congress finds and declares that—

(1) pregnancy is a normal and healthy physiological process;

(2) advanced medical technologies have been used in the treatment of uncomplicated pregnancies where the

medical benefits from such use have not been clearly shown to be cost-effective;

(3) use of such technologies by or under the supervision of qualified physicians is justified in the treatment of complicated pregnancies; and

(4) the current fee-for-service method for reimbursement of maternity care under the medicaid program does not provide either for incentives to limit the cost of such care or for identification of the cost of the total package of services normally provided in such care.

(b) It is the purpose of this Act to require each State to reimburse health facilities on a preestablished, all-inclusive rate for the provision of comprehensive routine maternity services by nurse-midwives under the State's medicaid plan.

REQUIRING REIMBURSEMENT OF COMPREHENSIVE ROUTINE MATERNITY SERVICES UNDER MEDICAID PROGRAMS

SEC. 2. (a) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended (1) by striking out "and" at the end of paragraph (16); (2) by redesignating paragraph (17) as paragraph (18); and (3) by inserting after paragraph (16) the following new paragraph:

"(17) subject to section 1902(a)(13)(F), comprehensive routine maternity services (as defined in subsection (l)(1)) provided under the supervision of a nurse-midwife (as defined in subsection (l)(2)).".

(b) Section 1905 of such Act is further amended by adding after subsection (k) the following new subsection:

"(l) (1) The term 'comprehensive routine maternity services' means such health services, provided under the supervision of a nurse-midwife, as the Secretary determines, after consultation with any qualified nurse-midwifery organization, to be ordinary and appropriate in the prenatal, delivery, and postpartum care of a normal pregnancy, and includes such laboratory services, physician referral services, and family planning services as the Secretary determines to be ordinarily and appropriately incidental to the provision of such services.

"(2) The term 'nurse-midwife' means, with respect to provision of comprehensive routine maternity services in a State, a registered nurse who (A) has successfully completed a program of study and clinical experience, meeting such guidelines or certified by such organization or organizations as the Secretary may prescribe, in the provision of such maternity services, and (B) is legally authorized to perform (and coordinate the provision of) such services in the State.

(c) Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(12)) is amended—

(1) by striking out "and" at the end of clause (i) of subparagraph (A), and by inserting after clause (ii) of such subparagraph the following new clause:

"(iii) for the inclusion of the comprehensive routine maternity services described in clause (17) of section 1905(a); and"; and

(2) by inserting "and" at the end of subparagraph (E), and by adding after such subparagraph the following new subparagraph:

"(F) with respect to the provision under the plan of care and services described in clause (17) of section 1905(a), for (i) establishment of a single prospectively determined rate, based on similar rates charged by clinics and private insurers, for provision of all such care and services in the course of a normal pregnancy, and (ii) payment for the provision of such care and services in the course of a normal pregnancy in an amount equal to the proportion of all such services provided multiplied by the rate established under clause (i);".

(d) Section 1902(a)(14)(A)(i) of such Act (42 U.S.C. 1396a(a)(14)(A)(i)) is amended by striking out "clauses (1) through (5) and (7)" and by inserting in lieu thereof "clauses (1) through (5), (7), and (17)".

ESTABLISHMENT OF LIST OF SERVICES AND RATE GUIDELINES

SEC. 3. The Secretary of Health, Education, and Welfare shall establish, by regulation first established in final form

not later than the first day of the sixth month beginning after the month in which this Act is enacted, (1) a list of the specific health services which constitute comprehensive routine maternity services for a normal pregnancy under section 1905 (a) (17) of the Social Security Act and (2) guidelines for States to comply with the requirements of section 1902 (a) (13) (F) of such Act (relating to establishment of a single prospectively-determined rate for such services and proportional payment for provision of such services).

EFFECTIVE DATES

SEC. 4. (a) Except as provided in subsection (b), the amendments made by this Act shall apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after October 1, 1977.

(b) The amendments made by section 2 (c) (1) shall apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than thirty days after the date the Secretary of Health, Education, and Welfare has established the list and guidelines described in section 3 of this Act.

95TH CONGRESS
1ST SESSION

H. R. 6259

IN THE HOUSE OF REPRESENTATIVES

APRIL 18, 1977

Mr. CARTER introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend title XVIII of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) With respect to rural health clinic services, payment shall be made, on behalf of an individual and in the manner described in section 1845 (after such section becomes effective), on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate.".

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"(aa) (1) The term 'rural health clinic services' means such services and supplies as would otherwise be covered (under subsection (s) (2) (A)) if furnished as an incident to a physician's professional service and such additional services provided by a physician extender as he is legally authorized to provide in the jurisdiction in which he performs such services, so long as such services and supplies are furnished by a rural health clinic to an individual as an outpatient with respect to whom such services are periodically reviewed by a physician (as defined in section 1861 (r) (1)). Such term also includes preventive health services furnished by a physician or physician extender (if such extender is legally authorized to perform such services) to an individual as an outpatient of such a clinic.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians under which provision is made for the periodic review, as is determined necessary by the super-

vising physician, of all services furnished by physician extenders, the supervision and guidance by such physicians of physician extenders, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of patients as is necessary and for advice and assistance in the management of medical emergencies;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals for the referral or admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has written policies to govern the management of the clinic and all services it provides;

"(F) has a physician or physician extender responsible for the execution of such policies relating to the provision of the clinic's services;

"(G) has access to diagnostic services from facilities meeting requirements under this title;

"(H) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals;

"(I) is governed by a board, a majority of which

is composed of residents who live in the area served by the clinic and who are not the physician extender or supervising physician of the clinic; and

"(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For purposes of this title, such term includes only a facility which (i) is not located in an urbanized area (as defined by the Bureau of the Census) but is located in an area where the supply of medical services is not sufficient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302(7) of the Public Health Service Act, and including facilities in any area so long as the facility receives a majority of its patients from rural areas having medically underserved populations), and (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed, with respect to such items or services, pursuant to subsections (a) and (b) of section 1833.

"(3) The term 'physician extender' means, for the

purposes of this subsection, a physician assistant, medex, nurse practitioner, nurse clinician or other trained practitioner (A) who performs, under the supervision of a physician (as defined in section 1861(r)(1)), such services as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and (B) who is certified as a physician assistant by the National Commission on Certification of Physician Assistants, or successor organization, or is certified as an adult-family nurse practitioner by the American Nursing Association, or successor organization.

"(4) The term 'preventive health services' means—

"(A) physical exams, and diagnostic services made in connection with any such exam, conducted for the purpose of assessing an individual's physical condition without regard to whether such individual has manifested symptoms of illness;

"(B) home health visits;

"(C) health education and counseling designed to prevent nutritional or other medical problems of the elderly, including counseling for conditions of terminal illness;

"(D) rehabilitative and physical therapy services;

"(E) immunizations and services related thereto;

"(F) services for illness management designed to minimize handicapping and discomforting conditions due to a chronic illness; and

"(G) preventive dental care."

(c) Section 1862 (a) (3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861 (aa) (2), and in other cases".

(d) (1) Section 1861 (s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services."; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864 (a) of such Act is amended by striking out "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(3) Section 1862 (a) of such Act is amended—

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(A) by inserting the following before the semicolon at the end of paragraph (1): "(except for preventive health services furnished as part of rural health clinic services)";

(B) by inserting after "physical checkups" in paragraph (7) the following: "(other than physical checkups furnished as part of rural health clinic services)"; and

(C) by inserting "(except for preventive dental care services furnished as part of rural health clinic services)" after "care" in paragraph (12).

(e) Part B of title XVIII of the Social Security Act is amended by adding the following new section at the end thereof:

"PROSPECTIVE BUDGETS AND PAYMENTS TO RURAL HEALTH CLINICS

"SEC. 1845. (a) Beginning as soon as practicable, as determined by the Secretary, after the effective date of this section, the Secretary may not pay any rural health clinic for services provided under this title in a fiscal year unless the clinic has submitted, and the Secretary has approved in accordance with this section, a prospective budget for the clinic for the fiscal year, including an estimation in such budget of the amount of services which are to be rendered

by such clinic and for which payment will be made under this title. Such budget shall be formulated and submitted in accordance with regulations submitted by the Secretary.

"(b) After subsection (a) is implemented, the Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid for services under this title for such quarter to each rural health clinic whose budget has been approved under subsection (a). Such estimate shall be based upon such budget and the amount already paid for such services to the clinic for services during the fiscal year. After making such estimate, the Secretary shall pay (at the beginning of such quarter and prior to audit and settlement by the General Accounting Office) to the clinic, or to the physician in the case of a clinic in which the physician extender is an employee of the physician, the amount of such estimate. At the end of each fiscal year, the Secretary shall determine, with respect to each rural health clinic, if any discrepancy exists between the payments made during such year to the clinic and the amount to which the clinic is entitled under this title for such year. The Secretary shall, then, make payments to, or receive payments from, such clinic in order to correct such discrepancy.".

(f) The amendments made by this section shall apply to services rendered on or after the first day of the third

calendar month which begins after the date of enactment of this Act.

SEC. 2. The Secretary may initiate and carry out demonstration projects in selected urban areas where the supply of medical services is not sufficient to meet the needs of individuals residing therein. In carrying out such projects, the Secretary shall make payments on behalf of individuals for services described in section 1861 (aa) (1) of the Social Security Act, except that such services shall be furnished to outpatients by health clinics located in the selected urban areas rather than by a rural health clinic. Such health clinics shall be primarily engaged in providing such services and shall meet the requirements of subparagraphs (B) through (J), and clause (ii) of the last sentence, of section 1861 (aa) (2) of such Act. Eligibility for, the amount of benefits payable with respect to, and the manner of payment for such services shall be determined in the same manner as they are determined with respect to rural health clinic services under title XVIII of such Act.

95TH CONGRESS
1ST SESSION

H. R. 2504

IN THE HOUSE OF REPRESENTATIVES

JANUARY 26, 1977

Mr. ROSTENKOWSKI introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend title XVIII of the Social Security Act to provide payment for rural health clinic services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) With respect to rural health clinic services, payment shall be made, on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate.".

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"(aa) (1) The term 'rural health clinic services' means such services and supplies as would otherwise be covered (under subsection (s) (2) (A)) if furnished as an incident to a physician's professional service, and such additional services provided by a physician extender as he is legally authorized to provide in the jurisdiction in which he performs such services, furnished by a rural health clinic to an individual as an outpatient with respect to whom such services are periodically reviewed by a physician (as defined in section 1861 (r) (1)).

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians under which provision is made for the periodic review by such physicians of all services furnished by physician extenders, the supervision and guidance by such physicians of physician extenders, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of patients as is necessary and

for advice and assistance in the management of medical emergencies;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has policies, which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more physicians and one or more physician extenders, to govern the services referred to in subparagraph (A) which it provides;

"(F) has a physician or physician extender responsible for the execution of such policies relating to the provision of the clinic's services;

"(G) directly provides routine diagnostic services, including clinical laboratory services, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

"(H) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

"(I) meets such other requirements as the Sec-

retary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For purposes of this title, such term includes only a facility which (i) is located in a rural area where the supply of medical services is not sufficient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302(7) of the Public Health Service Act), (ii) is not a physician-directed clinic under direct personal physician supervision, and (iii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed, with respect to such items or services, pursuant to subsections (a) and (b) of section 1833.

"(3) The term 'physician extender' means, for the purposes of this subsection, a physician's assistant, medex, nurse practitioner, or any other such practitioner who performs, under the supervision of a physician (as defined in section 1861(r)(1)), such services as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who

meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(c) Section 1862 (a) (3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861 (aa) (2), and in other cases".

(d) (1) Section 1861 (s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services."; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864 (a) of such Act is amended by striking "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(e) The amendments made by this Act shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

[H.R. 8422, 95th Cong., 1st sess.]

[Report No. 95–548, Part I]

A BILL To amend title XVIII of the Social Security Act to provide payment for rural health clinic services

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

That (a) section 1832(a) of the Social Security Act is amended—

(1) by striking out "paragraph (2)(B)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B) and (D) of Paragraph (2); *and*

(2) by striking out "and" at the end of paragraph (2)(B)(i)(II) and inserting in lieu thereof "or", and by adding the following new subclause at the end of paragraph (2)(B)(i):

"(III) a physician when such services are rural health services, and"; and

(3)(2) by striking out the period at the end of paragraph (2)(C) and inserting in lieu thereof "; and" and by adding the following new subparagraph at the end of paragraph (2):

"(D) rural health clinic services."

(b) Section 1833(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (1);

(2) by inserting "(except those services described in subparagraph (D) of section 1832(a)(2))" in paragraph (2) after "1832(a)(2)";

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; and"; *and*

(4) by inserting the following new paragraph after paragraph (2):

"(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A)."

(c) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Rural Health Clinic Services

"(aa)(1) The term 'rural health clinic services' means—

"(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service, and

"(B) such services furnished by a primary care practitioner and such services and supplies furnished as an incident to this service as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

when furnished to an individual as an outpatient of a *rural health* clinic.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) *in the case of a facility which is not a physician-directed clinic,* has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in section 1861 *subsection* (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by primary care practitioners, the supervision and guidance by such physicians of primary care practitioners, the preparation by such as may be necessary, and the availability of such physicians for such referral of patients as is necessary and for advice and assistance in the management of medical emergencies; except that *and* in the case of a physician-directed clinic, such clinic shall have *has* one or more of its staff physicians perform the activities accomplished through such an arrangement;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals meeting the requirement under this title for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has policies, which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional

personnel, including one or more physicians and one or more primary care practitioners, to govern the services referred to in subparagraph (A) which it provides;

"(F) has a physician or primary care practitioner responsible for the execution of such policies relating to the provision of the clinic's services;

"(G) directly provides routine diagnostic services including clinical laboratory services as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

"(H) has available for administering to patients of the rural health clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements in compliance with State and Federal law for storing, administering, and dispensing any drugs and biologicals; and

"(I) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in a rural area designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a primary care practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases.

"(3) The term 'primary care practitioner' means, for the purposes of this subsection, a nurse practitioner or physician assistant who performs such services as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(d) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, *clinic services*, as defined in section 1861(aa)(2), and in other cases".

(e)(1) Section 1861(s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services."; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864(a) of such Act is amended by striking "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(e) Section 1861(s)(2) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (C)(ii);

(2) by inserting "and" at the end of subparagraph (D); and

(3) by adding the following new subparagraph at the end thereof:

"(E) rural health clinic services;".

(f) Section 1864(a) of such Act is amended—

(1) by inserting "or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2)," in the first sentence after "home health agency,";

(2)," in the first sentence after "home health agency,";

(2) by inserting "rural health clinic," in the second sentence after "nursing facility,"; and

(3) by inserting "rural health clinic," in the last sentence after "facility," each time it appears therein.

(g) The amendments made by this section shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

SEC. 2. (a) The Secretary shall provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under title XVIII of the Social Security Act and, notwithstanding any other provision of title XVIII, for services provided by [physician extenders] *primary care practitioners* employed by such clinics which would otherwise be covered under such title if provided by a physician.

(b) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

(1) the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing [physician extenders] *primary care practitioner;*

(2) the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics;

(3) the appropriate definition for such clinics;

(4) the appropriate criteria to use for the purposes of designating urban medically underserved areas; and

(5) such other possible changes in the present provisions of title XVIII of the Social Security Act as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such [grant] *grant*, payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary, giving due regard to the purposes of the demonstration projects.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration [project] *projects* conducted under subsection (b). Such report shall include and recommendations for legislative changes which the Secretary finds necessary or desirable as a result of carrying out such demonstration [project] *projects*.

SEC. 3. (a) The Secretary, directly or through contracts with or grants to public or private agencies or organizations, shall develop and carry out demonstration projects to provide reimbursement under title XVIII for services provided in organized centers offering comprehensive outpatient mental health services.

(b) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

(1) the relative advantages of various types of reimbursement, including reimbursement on a cost basis for outpatient mental health services;

(2) the relative effects on utilization and cost of services resulting from [(i)] (*A*) various definitions for outpatient mental health services covered under title XVIII of the Social Security Act (when provided by a center described in subsection (a)) and [(ii)] (*B*) various limitations on such services;

(3) the appropriate definition for such a center;

(4) the appropriate definition of and qualification for individuals who provide services in such centers for which reimbursement is made under title XVIII or this section, including their appropriate professional relationships; and

(5) such other changes as might be appropriate for the more efficient and cost-effective reimbursement of outpatient mental health services provided under title XVIII of the Social Security Act.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this section shall be made in appropriate part

from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary, giving due regard to the purposes of the demonstration projects.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration projects conducted under subsection (b). Such report shall include any recommendations for legislative changes in title XVIII of the Social Security Act which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

(e) In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of title XVIII of the Social Security Act insofar as such requirements relate to methods of payment for services provided; and costs incurred in such experiement or project in excess of those which would otherwise be reimbursed or paid under such title may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary).

Amend the title so as to read: "A bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services, and for other purposes.".

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MAY 23 1977

The Honorable Harley O. Staggers
Chairman, Committee on Interstate
and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for a report on H.R. 791 and on an identical bill, H.R. 1955, bills "To amend Title XVIII of the Social Security Act to authorize payment under the supplementary medical insurance program for services furnished by physician extenders."

In summary, we oppose these bills because we believe that Medicare reimbursement policy should encourage physician extenders to locate and practice in medically underserved areas. In addition, we believe cost-based payment for physician extender services to be more efficient and less susceptible to program abuses than fee-for-service payment.

These bills would add physician extender services provided under general physician supervision to the medical and other health services which are covered under Medicare Part B. Currently Medicare limits payment for physician extender services to those services which are furnished as an incident to a physician's services under direct physician supervision.

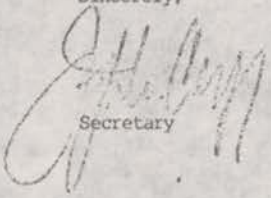
The Administration has proposed in the revised FY 1978 Budget to provide cost-related Medicare payments to clinics in medically underserved areas that employ physician extenders. We prefer limiting Medicare payment for physician extender services to those who work in underserved areas rather than paying for services in all areas for two reasons. First, limiting payment for services to physician extenders who work in underserved areas provides an incentive for them to locate in medically underserved communities. Without incentives such as this, physician extenders could be expected to follow the location pattern of physicians, leaving rural areas and inner cities medically underserved. Second, it is not known whether physician extenders practicing in areas with adequate numbers of physicians will perform primary care services in lieu of physician services or if they will merely supplement physician care. If the latter is the case, the inflationary impact of paying for physician extender services would be great.

We also prefer limiting payment for physician extender services to those provided in clinic settings and making such payments cost related, rather than paying fee for service in all settings. Cost-related payment should aid in containing increases in Medicare costs. Fee-for-service reimbursement provides incentives for increasing the volume of services provided which, in turn, increases overall costs. Furthermore, reasonable cost payment to clinics offers safeguards against fraud and abuse.

We therefore recommend that these bills not be favorably considered.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



Secretary

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

MAY 10 1977

Honorable Harley O. Staggers
Chairman, Committee on
Interstate and Foreign Commerce
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This is in response to your request of February 28, 1977 for the views of this Office on H.R. 2504, a bill "To amend title XVIII of the Social Security Act to provide payment for rural health clinic services."

In testimony before your Committee on February 28, 1977, the Department of Health, Education, and Welfare stated that it supported H.R. 2504, but recommended four amendments to improve the bill. These amendments would:

-- allow clinics in all underserved areas to participate;

-- permit physician-directed clinics to participate;

-- reimburse clinics for physician supervisory and direct services on a salary-equivalent basis; and

-- eliminate the setting of standards for physician extenders by the Secretary and reimburse only for services usually provided by physicians.

With respect to the last recommendation, we understand that the Department is working on an amendment which would permit the Secretary to set conditions of participation for rural clinics that could include minimum qualifications for their physician extenders.

We concur with the views expressed by the Department of Health, Education, and Welfare and, subject to the changes suggested by the Department, recommend favorable consideration of H.R. 2504.

Sincerely,

James M. Frey

James M. Frey
Assistant Director for
Legislative Reference

Mr. FLORIO. Now I would like to call upon Dr. Karen Davis of the Department of Health, Education, and Welfare. She is accompanied by Mr. Ronald Klar, who is Acting Director of the Office of Policy Development and Planning, in the Office of the Assistant Secretary for Health.

STATEMENT OF KAREN DAVIS, Ph. D., DEPUTY ASSISTANT SECRETARY FOR HEALTH PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY RONALD M. KLAR, M.D., ACTING DIRECTOR, OFFICE OF POLICY DEVELOPMENT AND PLANNING, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Dr. DAVIS. Thank you, Mr. Chairman.

It is a pleasure to be here today to share with you the Department's views on the amendment to H.R. 8422, which provides for medicaid reimbursement on a reasonable cost basis for services provided in rural health clinics in medically undeserved areas. The Department commends this committee for recognizing this important problem and for your initiative in introducing this bill.

The Department strongly supports efforts to assure access to quality medical care for all citizens. We have supported the bills sponsored by Congressman Rostenkowski and Senator Dick Clark, which would provide for medicare payments to clinics in rural underserved areas for services provided by primary care practitioners.

Mr. Chairman, the Department supports the expansion of this legislation to include coverage under the medicaid program. We believe this legislation, while in and of itself is not sufficient to assure the financial self-sufficiency of rural health clinics, is a necessary step in doing so, and will promote access to care for all Americans regardless of where they live.

Assuring access to care for residents of rural underserved areas is a difficult problem. Over one-third of all rural residents live in areas designated as medically underserved. A significant proportion of these people have incomes well below the poverty level. The rural population has a heavy concentration of aged people and young children: there are 9 dependent people, those under the age of 18 and over the age of 65, for every 10 working age adults in rural areas. Rural residents often face special social and environmental health hazards such as substandard housing and impure water supplies.

Health statistics reflect the impact of poverty and environmental conditions on rural residents. People living in rural areas tend to have a high incidence of serious health problems. They are disproportionately afflicted with chronic, disabling conditions. Infant mortality rates are inordinately higher in some rural areas, especially among minorities and in high poverty areas. The incidence of severe dental conditions, nonimmunized children, mental illness, and malnutrition are significantly higher among the rural poor.

Despite the great need for health services, the rural poor have access to fewer health care resources than most Americans. The lack of adequate primary care physicians and ambulatory health facilities is a

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serious problem. Support services, such as laboratory services and transportation services, are often unavailable in sparsely populated rural settings.

The limited access to ambulatory health services has contributed to the lower use of preventive and health maintenance services among rural residents, and increased the dependence on crisis-oriented and more costly episodic care. For example, the percentage of rural residents who have never had an EKG, chest X-ray, eye examination, or routine physical is well above the national norm. Moreover, the percentage of rural women who have never undergone a Pap smear or breast examination is also significantly higher.

The Department, through its rural health initiatives—the National Health Service Corps, the health underserved rural areas (HURA) program, and related health manpower delivery activities, is committed to improving the health care delivery capability in medically underserved areas. The HURA program, funded by medicaid, is a demonstration and research project attempting to consolidate and supplement existing services and facilities in rural areas so that a wider population can be better reached. Nearly 400 physicians, primary care practitioners and other health care personnel, are supported in the 53 project sites.

The primary health center model shows considerable promise as an effective and viable delivery system for some rural communities. These centers are typically staffed by nurse practitioners or other primary practitioner personnel and have a strong record in successfully recruiting and retaining personnel. Experience with this model suggests that primary health services can be provided at a relatively low cost in many communities. Existing primary center programs, such as the North Carolina Rural Health Services Program and the Frontier Nursing Service and the University of Florida Physician Assistant Program have demonstrated the effectiveness of this model in increasing access to high quality health services in less populated rural areas.

However, the resource development programs of the Department and other State-supported activities alone are not sufficient to assure access to health care services for residents of rural, underserved communities. Public and private insurance programs must support the facilities and health care personnel located in these communities if they are to have a true opportunity to become economically viable.

Mr. Chairman, we strongly support this legislation, which we estimate will increase State Medicaid spending at most by $14 to $18 million and Federal medicaid expenditures by no more than $17 to $22 million in the first full year.

More recent estimates would indicate that these sums are probably somewhat lower. These estimates were based upon the assumption that 40 to 50 percent of the clinic's services would go to Medicaid recipients.

The experience of our rural community health centers sponsored by the Department, however, is that about 20 percent of the services go to medicaid recipients; that would cut these cost estimates in about half. So we are talking about perhaps $12 million in Federal medicaid expenditures, and about $10 million in State medicaid expenditures.

Mr. Chairman, we would like to work with the subcommittee staff on technical changes to this legislation which we believe the subcommittee should consider.

My colleagues and I would be pleased to answer any questions you may have.

Mr. FLORIO. Thank you very much.

As of now, I understand that approximately 20 States reimburse under medicaid for the services of comprehensive health services. Would you elaborate on exactly what is entailed?

Dr. DAVIS. Yes. Currently about all but 11 States do cover some clinic services in their medicaid benefit packages. However, many of the remaining 39 States reimburse for a very narrow range of clinic services, predominantly those which are otherwise mandated in a State plan or those provided in State-supported clinics. In fact, only 22 States are now paying for comprehensive primary care services in clinic settings, and only 17 of these pay for services provided by nurse practitioners and physician assistants in these settings.

So some States have taken steps in this area, but I think actually a fairly small proportion of the States explicitly cover the services of nurse practitioners and physician assistants in these settings. So the legislation would be quite significant in improving access to care.

Mr. FLORIO. Do you believe the Congress should mandate services in existing State plans?

Dr. DAVIS. We feel that the States have not to date addressed this problem. But we feel it is an essential service, just as physician services and hospital services which are mandated under the medicaid program. Therefore, it would be desirable to insure that these services are covered in all of the States.

Mr. FLORIO. The Secretary will ultimately define rural. Do you have any information as to what his intent is in terms of that definition?

Dr. DAVIS. Yes; we have testified on Senator Clark's bill, S. 708, in the Senate and have indicated our support for the fairly broad definition contained in that bill, which would extend coverage to all nonurbanized areas where urban was defined as a population of 50,000 or more. That is our thinking at the present with regard to the way we would define rural.

Mr. FLORIO. It is my understanding that one of the administration's major initiatives this year is going to be the child health assessment program. We expect to take up legislation dealing with that in the very near future. One of the goals of the CHAP program is to have more preventive assessment treatment services for children in comprehensive health centers.

It seems to me the rural health clinics would be the ideal providers for the CHAP program. Has any thought been given to that?

Dr. DAVIS. Yes, Mr. Chairman, we agree with you on that point. The child health assessment program is one of the administration's top health legislative priorities, and this bill that you are considering today would in many ways complement that legislation. The child health assessment program does several things.

First of all, it expands medicaid coverage to cover all low-income children under the age of 6. Currently, the States have the option of covering any low-income children under the age of 21. We would require under this legislation that they do it for at least those children under 6. Many States do not now cover all low-income children because they restrict coverage under medicaid to one-parent families. Children

in two-parent families do not qualify for AFDC and therefore do not qualify for medicaid. Many of these children are in rural areas. The rural poor differ considerably from the urban poor in family composition. About 70 percent of family members, poor family members in rural areas, belong to these two-parent families that tend to be excluded from the medicaid program, whereas in urban areas a slight majority of families are in one-parent families.

The restrictions on medicaid eligibility are a serious problem in rural areas and the child health assessment program would bring in many more children. Therefore, we would like to assure that services are available for them through financing such as contained under this bill.

The second point—and the one that you raised—is under the CHAP legislation the Federal match would be increased for all services that get to children who receive comprehensive health assessments. The Federal match would increase to about 75 percent in all of the State plans.

If a child got into a preventive program, and received a comprehensive health assessment, that higher match would apply not only to the assessment but to all subsequent ambulatory care. We are trying to encourage through this program, which modifies and improves the current early and periodic screening, diagnosis, and treatment program, an emphasis upon having children assessed and their ongoing care provided in comprehensive health care centers or primary health care centers such as would be covered under this bill. So assuring adequate health centers would very much complement our interest in this other legislation.

Mr. FLORIO. The bill restricts eligibility for clinics as to medically underserved areas. With that definition has there been any problm with regard to designating areas as medically underserved which are in need of services?

Dr. DAVIS. The Department currently uses two sets of definitions for medically underserved areas. Under the community health center program we use an index called medically underserved areas, which is based upon poverty rates, infant mortality rates, proportion of the population over age 65 and physicians per capita ratios. We also have another index which we use for our national health service corps program which emphasizes primarily the physician-population ratio.

Perhaps Dr. Klar would like to expand upon it.

Dr. KLAR. Yes. The areas in latter category, which are referred to as critical health manpower shortage areas are somewhat fewer than the medically underserved. As of October of 1976 we had designated approximately 2,400 counties in the United States as being wholly or in part medically underserved and 1,248 as critical health manpower shortage areas. They do overlap for the most part. Of the 2,400 medically underserved areas, only 161 do not include an area that is also defined as a critical health manpower shortage area. So for the most part we are able to cover most of the underserved areas by either definition under medically underserved.

Mr. FLORIO. Do you have any philosophic problems of including nurse midwives as primary health care practitioners?

Dr. DAVIS. We do not have any problem covering nurse midwives so long as they are practicing in accordance with State law and meet such education, training, and experience requirements which the Secretary may require that are designed to cover the nurse-midwife, nurse practitioner, and physician assistant. We did not address this, of course, in the context of the medicaid legislation, but feel that the term "nurse practitioner" is widely understood to be comprehensive enough to subsume the nurse midwife category, but we would be prepared to have that spelled out.

Perhaps Dr. Klar would like to comment.

Dr. KLAR. Yes; we have looked at the issue related to the State, and our best information suggests now that there are no longer any States which specifically exclude the practicing of nurse midwives within that State. Recently there were changes in the States of California, Colorado, and Massachusetts which did have some restrictions, but those have been removed from their Medical Practice Act, so under the supervision of a physician they can practice and approximately two-thirds of the nurse midwives are practicing in hospital settings in the obstetrical departments under physician supervision.

There are special certifying examinations for nurse midwives, and to the extent that this was met and any special State requirements that now exist in about a third, about 13 of the States, it would be covered under this bill as written.

Mr. FLORIO. My final question. This bill requires that the State reimburse rural health clinics on a cost basis for all services covered by the State medicaid plan. Will this result in a change of the reimbursement mechanism for such services as home health, dental services, and drugs?

Dr. DAVIS. We would like to look at this a bit more in terms of some of the home health services. In general, we would like to have reimbursement under the medicaid program, when we are talking about new providers, to be consistent with the medicare program. We have had within the Department a major reorganization so that the medicare and medicaid programs are in the Health Care Financing Administration. We are pleased with the approach in this bill linking the reimbursement of these clinics to reimbursement under the medicare program.

Some of the specific services such as home health I think we would like to look at a bit further.

Mr. FLORIO. Thank you both for your testimony and responsiveness to the questions.

Dr. DAVIS. Thank you very much.

Mr. FLORIO. Dr. David T. Allen.

STATEMENT OF DAVID T. ALLEN, M.D., DEPUTY COMMISSIONER, TENNESSEE DEPARTMENT OF PUBLIC HEALTH

Dr. ALLEN. Mr. Chairman, thank you very much for the opportunity to be here. Personal plans made notification late, so I don't have written testimony, but will get appropriate testimony into the record.

I am a physician and am deputy commissioner for the Tennessee Department of Public Health. We have been extremely interested in

access to health care. Several of the points which I hope to emphasize have been mentioned already.

I put in one statistic in support of my testimony that is specific for Tennessee. In 1930, 488 towns in Tennessee had their own physician and by 1970 there were only 218 towns that had their own physician. But folks in those other 200 towns remember the good old days, and still feel they deserve their own doctor.

Since 1973 we have had an amendment to our State medicaid act through which we have been able to reimburse community health clinics. It is clear to us that the success of these clinics, as a matter of fact, their very survival, is going to be dependent upon the ability of these clinics to tap all sources for reimbursement for the services that they deliver. Therefore, I would like to support the contention that changes in legislation such as your are discussing, are very necessary.

A second legislative act significant for improving health care in the State of Tennessee passed in 1973, the primary care act. I would like to read the first section of that act because it conveys a certain level of urgency recognized in Tennessee to improve access to health care. Section 1 reads, "The Department of Public Health is authorized to establish one or more primary health care centers in Tennessee. It is the intent of the General Assembly that the establishment of these centers will demonstrate new and more effective ways of providing health care in smaller communities of the State and will assist in achieving a better distribution of health care personnel into non-metropolitan areas of Tennessee where a shortage of such personnel currently exists, and that these centers will provide primary health care services to patients, and will enhance the delivery of health care in communities."

This act passed in 1973, and since then we heave learned much about what things can be done, and we have learned about many things that cannot be done, as a result of our demonstration projects.

I would encourage consistency between medicare and medicaid. This concept has been mentioned in a couple of ways, particularly with respect to the rules that are used for establishing the background accounting methods, and the mechanisms through which reimbursement is to be arranged. Also, comparable methods should be used for the establishment of reasonable cost.

Many of our health care providers now participate in various aspects of medicaid, and they must use many different provider-numbers as a function of the various services they deliver. If they want to deliver community health services in Tennessee, they have one specific number for that group of services. That is an agency billing number. If they wish to provide home health care, they have to have a second billing number, and in most cases they have to have a separate set of books to keep their accounts straight for medicare.

If all of the various services could be done under one agency number and one means of accounting it would facilitate tremendously the managerial tasks that face people who wish to establish rural clinics.

In the State of Tennessee, in medicaid we have several subsets of numbers associated with (1) the early periodic screening, diagnosis,

and treatment program; (2) the home health care services; (3) juvenile dental services, et cetera.

I think it is also important that we recognize that the community health center or the rural health center can support a very broad range of services that sometimes are delivered by various levels of specialists. Many of these services can be delivered very well by nurse practitioners and physician assistants, and in my judgment this reimbursement should not be limited to, or should not require, over-the-shoulder supervision to be onsite at all times, which has already been discussed.

We in Tennessee have been experimenting with various kinds of telephone supervision and with various frequencies of over-the shoulder supervision. I think the supervision can vary as a function of the complexity of the services delivered, and as a function of the training of the agent working with the physician. I am sure that one would not want to defer to State laws on licensure or certification, but I think it should be behind some of our thinking here at the Federal level, as well, that some kinds of local restrictions could make it impossible to deliver services using newer methodologies.

In Tennessee, our experience has been predominantly with nurse practitioners, rather than with physician's assistants, and we have been very pleased with the success of the expanded service delivery possibilities. I would also hope that there would be a broad range of services available for reimbursement underneath this rubric. They would include physical therapy, nutrition counseling, patient education on specific diseases, et cetera. I would like to emphasize at this point that we would want to have these services reimbursed both for services delivered by people who are full time as well as part time with any specific provider agency.

There are many areas within the State of Tennessee where we cannot hire physical therapists to live and work in that part of the State. But they could come in on a scheduled basis, on a day or two a month or maybe a day or two a week, and if they could then be reimbursed coming in on part time that would help.

Also, in many cases a physical therapist can initiate a routine with a patient and teach the nurse who is in residence in that town all the time to do certain services, so I would hope that reimbursement would not be keyed exclusively to single pedigrees, for example, limiting reimbursement to pedigrees of providers. In other words, physical therapy services might sometimes be delivered by a nurse, after the nurse has had the appropriate assistance. Laboratory services, simple ones like a dipstick urine test, could easily be done by many levels of personnel (and are done all over Tennessee by a nurse or nurse's aide). However, if one were to require the pedigree of a certified medical technician, for instance, it would be virtually impossible to deliver certain services in several areas of the State.

Therefore, evaluation, or the quality assurance, for such services should be based on performance along with a pedigree, and not just by pedigree alone.

There is another point of contention in the specific bill that is being proposed. There is a subsection that states that these clinics must make

available referrals to hospitals. I would like to point out that it is very difficult for many clinics to be the initiator of any guarantee of success in referrals. In my judgment it might help if some obligation could be placed on the hospital, or the secondary and tertiary providers to accept referrals rather than on the referring clinic to initiate them. The clinic has a very weak position from which to negotiate the acceptance of medicaid referrals, since many of our hospitals are reluctant to accept medicaid patients.

Thank you very much for the opportunity to be here, Mr. Chairman. I would be delighted to answer any questions.

Mr. FLORIO. Thank you very much.

I agree with many of the concepts you have tealked about, particularly the idea that the supervisor may not necessarily be the person that is rendering the service. We should not have to have direct supervision when it clearly is inappropriate.

I have found the practice of requiring a physician to come in to sign off on something he is unaware of, particularly time-consuming and wasteful, and certainly not very cost-effective. I certainly think that should be one of the thrusts down the line; the greater use of nurse practitioners and physician extenders, and so on.

In your own State, do you pay the clinic under the clinic program for all services covered by the State medicaid plan, or do you pay for drugs through a pharmacy or dental services through dentists?

Dr. ALLEN. In the State of Tennessee we have had several services evolve concurrently so that right now, for instance, we have some community health clinics that are reimbursed for their dental services or pharmacy services under their community health billing number, but there are few sites that collect for a few specific services under separate provider numbers. For instance, some dental services developed before the community health center legislation passed and some centers still bill medicaid for dental care using an independent dental billing number. So we have two kinds of experience. But our recommendation is that the legislation be designed so that these centers can have everything under one set of rules for accounting and bookkeeping—and that is not currently the case in community health centers in Tennessee.

Mr. FLORIO. In a specialized type clinic that may not give the broadest range of services, can you conceive of a situation whereby the physician is the consultant; that is, the clinic provides the service through the use of physician assistants or nurse practitioners, and physicians are on call as consultants? You had alluded to this concept in a different way.

Dr. ALLEN. Yes. Yes, I think that there are many situations in which patients will have self-limited, periodic diseases, or stabilized chronic diseases that require maintenance care for which the physician is clearly the consultant. Let's take a stabilized hypertensive who may need to see a physician with a known frequency, arbitrarily every 6 months, but he may need to have his blood pressure monitored on a much higher frequency. The physician may then be a consultant, if that answers your question.

Mr. FLORIO. What about nurse-midwife? Could a physician be a consultant to a nurse-midwife.

Dr. ALLEN. Yes, indeed. In Tennessee we do have a couple of nurse-midwife projects and we are very pleased with the success they have had and the projects we have had now are both within hospitals and the physicians, the attending OB staff are the supervision source of the midwife programs. As we currently have them the supervision is almost automatic because the physicians and midwives are in the same facility every day. But the physician is not looking over the midwife's shoulder for every patient every day, and so I think the physician is a consultant for the normal delivery now and should be.

Mr. FLORIO. Thank you.

Mr. Preyer, did you have questions?

Mr. PREYER. Thank you, Mr. Chairman.

I just want to applaud the chairman of the committee for holding these hearings. I think it is an idea whose time has come, and I am glad to see that we are turning more to solutions and emphasizing prevention.

Since upward, I understand, of 70 percent of physicians' work can be done by nurse practitioners or physician extenders, I think it is a waste of valuable resources to restrict them from providing care for medicaid and medicare patients. So I certainly support the extension of this bill to cover medicaid reimbursement.

The poor have had an unfortunate history with respect to preventive care and perhaps it is needed there more than any other area. One question I wanted to ask was along that line.

We have heard it said that it is difficult to encourage maximum utilization of health care among the poor. Do you have any thoughts on how consumer education can get at this problem? I am afraid that our efforts will fall short, even if we enact this worthy bill, unless the poor are made aware of the fact that preventative care is available to them.

Dr. ALLEN. Well, I think that it is a very important problem. I think that one of the major barriers to care has clearly been an economic one. And if people believe they are in debt as a result of coming to a provider, many people will voluntarily stay away until they feel they have no other choice, and then when the arm is broken or the appendix is hot, they feel they have no other choice.

The result is that when some diseases which may be amenable to early treatment and avoiding hospitalization begin the first response of the patient is: "I really can't afford to go. I will probably get better anyway." And if, in fact, we could support that first contract when the patient thinks something is wrong, I believe we could reduce subsequent hospitalization.

Now, that is preventive in the sense you are preventing the hospitalization, but it is therapeutic or curative in the sense that the motivator is the patient who has to come in when he thinks there is something already starting wrong. There is one other aspect to what you say. That is, I think we are at an age now where we can target certain populations and certain groups with certain expected frequencies for certain diseases. And I don't remember seeing anything in this particular bill that would allow a clinic to initiate that type of targeting in health education, but I think that responsibility really should rest with State departments and with regional health planning authorities

to target groups and then the health education efforts themselves might reasonably be included as reimbursable.

Mr. PREYER. Maybe this has been covered, but I will just ask. Do you have any of the latest figures on how many poor people are categorically ineligible for medicaid? What are the figures?

Dr. ALLEN. Well, in Tennessee we have a problem because in order to be eligible being poor is not adequate, you have to be categorically in one of the medicaid categories to be eligible for medicaid. I don't have that number, but I can try to get that for you.

Mr. PREYER. Well, just say in Tennessee, are there a lot or a few?

Dr. ALLEN. Are there a lot of people who are poor?

Mr. PREYER. And ineligible.

Dr. ALLEN. Poor and ineligible, I would say that answer is clearly that there are large numbers who are poor but who are ineligible for medicaid.

Mr. PREYER. Thank you very much, Mr. Chairman.

Mr. FLORIO. Thank you, Dr. Allen.

Dr. ALLEN. Thank you, Mr. Chairman.

Mr. FLORIO. Next we have a panel; Dr. Donald W. Fisher and Mrs. Connie Mullinix. Mrs. Mullinix is accompanied by Connie Holleran. I will allow you to decide who will go first.

Mr. FISHER. Ladies first.

STATEMENTS OF CONNIE MULLINIX, CHAIRPERSON-DESIGNATE, COUNCIL OF FAMILY NURSE PRACTITIONERS, AMERICAN NURSE ASSOCIATION; ACCOMPANIED BY CONNIE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS DIVISION, AMERICAN NURSES ASSOCIATION; AND DONALD W. FISHER, Ph. D., EXECUTIVE DIRECTOR, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Mrs. MULLINIX. Mr. Chairman, I am Connie Mullinix, a certified family nurse practitioner from Chapel Hill, N.C. I am here today as the chairperson designate of the ANA Council of Family Nurse Practitioners.

We are very pleased that you have been able to fit this hearing into your very busy committee schedule. I would like to submit a complete statement for the record and just highlight briefly here.

We support the bills, including the expansion to include medicaid.

You may recall that when this subcommittee held hearings on the current Nurse Training Act, several nurse practitioners described their practices in rural Maine, urban Albuquerque, N. Mex., and rural North Carolina. At that time they advised you of the problems in regard to reimbursement and gave examples. They noted that a patient could not collect from insurance companies for clinic or home visits, but that there were no questions about taking that same patient to a hospital by ambulance and paying full hospital costs for care. Such care could be more humanely and much less expensively provided in the home or in a nearby clinic. It is such situations that you are now trying to correct, and we strongly support that effort.

We believe that changes in reimbursement policies under medicare are long overdue to make possible the continuation of existing rural

clinics and the development of new ones. In fact, we support the reimbursement of health services such as those referred to in H.R. 8422, regardless of the setting in which they are delivered, rural or urban. Such reimbursement policies should apply for all clinics, not just satellite clinics. In fact we believe the services should be reimbursable in all settings.

Many isolated rural communities have not been able to attract or retain physicians, and therefore have come to rely on clinics as an alternative for delivery of health services. The continued existence of these clinics is endangered by current medicare regulations which prevent reimbursement unless a doctor is physically present.

Medicare authorizes coverage of services provided by nurse practitioners or physicians' assistants only if the services provided are under physician supervision and if the service is incident to a physician's service. Medicare restricts payment to "medical services." No one ever seems to define what constitutes "medical services" or to explain why if those same services are provided by a nurse, medicare still calls them "medical services." We do think this needs to be carefully reviewed by the Congress.

While we strongly support the need for legislation to permit reimbursement to rural clinics, we recommend certain changes. We were pleased to see the change made by the Ways and Means Health Subcommittee to substitute the term "primary care practitioner" for "physician extender" which was used in the original version of the bill to refer to both nurse practitioners and physician's assistants.

We do believe it is unnecessary for the bill to make reference to supervisory physician at all as it applies to nurses. We wish to emphasize the nurse practitioner is licensed as an independent health professional.

In most States the physician's assistant functions under a licensed physician. On the other hand, a nurse is licensed and registered to practice by the appropriate State agency. The law does not place the registered nurse under the direct supervision of any other health discipline. In the past few years, 31 States have revised their nurse practice laws to accommodate the expanded role of the nurse practitioner. The other 19 States have not found it necessary to change their law at this time.

A conservative estimate of nurses prepared to practice in this expanded role is 7,000. Of that number, more than 2,500 are prepared as family nurse practitioners able to provide a wide range of services to all age groups. Others are prepared in such specialities as geriatrics, school health, ob-gyn, pediatrics.

There is no question that the nurse practitioner participates in the medical regimen of care by carrying out the appropriate medical orders of the physician and by coordinating the activities and efforts of other health personnel who participate in the patient's care at different intervals.

It is also evident that a major portion of health care includes health promotion and health education, which the professional nurse does routinely.

In our complete statement I have given several examples of my own experience.

We also believe there must be a system of peer review and other quality assurance mechanisms in operation so as to evaluate effectively the care provided by nurse practitioners. Standards have been devel-

oped by the ANA for each specialty practice area, and adherence to these standards is considered essential to professional nursing practice.

We strongly urge that you replace the phrase "physician extender" with "nurse practitioner and physician assistant" or "primary health care provider" as was done by the Ways and Means Committee, and that you remove the requirement of M.D. supervision of the R.N. (nurse practitioner) and replace that language with "mutually agreed upon protocols and/or in accordance with State law."

We think these changes are appropriate and do not weaken the bill. They are in keeping with the nurse's legal responsibility for her/his practice. The State nurse practice acts do guide the changing and evolving role of the professional nurse to meet society's changing health needs.

As we have pointed out, nurse practitioners are legally liable for their practice, and they do carry their own malpractice insurance.

We hope that the committee will find these changes acceptable. We feel strongly that this legislation is very significant in helping to provide health care and improve continuity of health care, and we want to be able to support it all the way.

We appreciate the opportunity to appear here today and commend the committee for its attention to this significant legislation.

Mr. FLORIO. Thank you very much.

[Testimony resumes on p. 69.]

[Mrs. Mullinix's prepared statement follows:]

STATEMENT OF CONNIE MULLINIX, CHAIRPERSON DESIGNATE, COUNCIL OF FAMILY NURSE PRACTIONERS, AMERICAN NURSES ASSOCIATION

Mr. Chairman, I am Connie Mullinix, a certified Family Nurse Practitioner from Chapel Hill, North Carolina. I am here today as the chairperson designate of the ANA Council of Family Nurse Practitioners. With me is Connie Holleran, director of the ANA Washington Office.

We are very pleased that you have been able to fit this hearing into your very busy committee schedule. We think this is a most important piece of legislation. Rural health clinics are bringing essential health care to a badly underserved segment of our population. Medicare benefits for rural states range from $95 to $280 lower per recipient for rural than for urban areas. We are most eager to see that continuity of funding is available to the rural clinics.

You may recall that when this subcommittee held hearings on the current Nurse Training Act, several nurse practitioners described their practices in rural Maine, urban Albuquerque, New Mexico, and rural North Carolina. At that time they advised you of the problems in regard to reimbursement and gave examples. They noted that a patient could not collect from insurance companies for clinic or home visits, but that there were no questions about taking that same patient to a hospital by ambulance and paying full hospital costs for care. Such care could

be more humanely and much less expensively provided in the home or in a nearby clinic. It is such situations that you are now trying to correct, and we strongly support that effort.

We believe that changes in reimbursement policies under Medicare are long overdue to make possible the continuation of existing rural clinics and the development of new ones. In fact, we support the reimbursement of health services such as those referred to in H.R. 8422, regardless of the setting in which they are delivered, rural or urban. Such reimbursement policies should apply for all clinics not just satellite clinics. In fact we believe the services should be reimbursable in all settings.

Rural clinics, which were established largely in response to a lack of physician services, can be found in numerous locations throughout the country.

Many isolated rural communities have not been able to attract or retain physicians, and therefore have come to rely on clinics as an alternative for delivery of health services. The continued existence of these clinics is endangered by current Medicare regulations which prevent reimbursement unless a doctor is physically present. In many instances, as you heard in our testimony on the Nurse Training Act, these clinics are actually run by one or two nurse practitioners. Yet their financial stability is constantly threatened by unrealistic reimbursement policies.

In light of the federal funds that are spent to help prepare nurse practitioners, it seems very short sighted to restrict federal payment mechanisms in such a way as to discourage their most effective use.

Present federal law, with respect to reimbursement, does not prohibit private insurance from reimbursing rural health clinics which utilize non-physician personnel, and some states have had projects that have proven quite successful such as the Grand Island, Vermont - Blue Shield experimental reimbursement program. Many insurers, however, have chosen not to reimburse clinics. We think congressional action on this bill would also influence the private sector to change their policies in this respect. Under Medicaid, although states have the option of covering clinic services, only 27 states reimburse clinics. We hope you urge changes there as well.

Medicare authorizes coverage of services provided by nurse practitioners or physicians' assistants only if the services provided are under physician supervision and if the service is incident to a physician's service. Medicare restricts payment to "medical services." No one ever seems to define what constitutes "medical services" or to explain why if those same services are provided by a nurse, Medicare still calls them "medical services." We do think this needs to be carefully reviewed by the Congress.

While we strongly support the need for legislation to permit reimbursement to rural clinics, we recommend certain changes. We were

pleased to see the change made by the Ways and Means health subcommittee to substitute the term "primary care practitioner" for "physician extender" which was used in the original version of the bill to refer to both nurse practitioners and physician's assistants. We were also pleased to see that the provision for physician supervision was changed from supervision of all services to supervision of "covered services" meaning medical services covered by Medicare. Many services provided by nurses are not in any way classifiable as medical, things such as diabetic teaching, teaching family members to care for the ill member, and so on. We believe it is unnecessary for the bill to make reference to supervisory physician at all as it applies to nurses.

As we pointed out in our testimony before the Ways and Means health subcommittee, there are distinct differences between the nurse practitioner and the physician assistant.

These differences relate to (1) definition, (2) educational preparation, (3) focus of practice, and (4) legal requirements.

The American Medical Association has defined the physician's assistant as "a skilled person qualified by academic and practical on-the-job training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

In most states, physician assistants are not licensed. The employing physician determines the scope of practice and what is to be delegated to the physician assistant. State laws and regulations of physician assistants codify the authority of the physician to employ physician assistants.

The nurse practitioner, as defined by the American Nurses' Association Council of Family Nurse Practitioners and Clinicians, is a primary care provider prepared to give continuous, personalized care to the patient/client at the point of entry into the health care system, and to continue as the individual's care provider. The nurse practitioner is a registered nurse prepared in a degree-granting program or in a post-RN continuing education program.

A nurse practitioner's preparation consists of a specialized program of study beyond that required for RN licensure. It must meet the ANA Guidelines for Short Term Continuing Education Programs that prepare a nurse to function in an expanded role. Published guidelines include those written for pediatric, family, adult, school health, college health, and obstetric-gynecologic nurse practitioners. Programs range from 36-52 weeks in a continuing education program to programs granting baccalaureate and master's degrees.

The Divisions on Practice of the American Nurses' Association provide for certification of nurse practitioners. To date, more than one thousand nurses have entered the certification process.

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A nurse practitioner is an independent licensed health care professional responsible and legally accountable to the consumer. The nurse practitioner is expected to make complex professional judgments on a wide range of patient care problems. These judgments can and often do mean the difference between life and death. Like other health care professionals, the nurse practitioner must carry personal liability insurance.

We must emphasize that the nurse practitioner is licensed as an independent health professional. In most states the physician's assistant functions under a licensed physician. On the other hand, a nurse is licensed and registered to practice by the appropriate state agency. The law does not place the registered nurse under the direct supervision of any other health discipline. In the past few years, 31 states have revised their nurse practice laws to accommodate the expanded role of the nurse practitioner. The other 19 states have not found it necessary to change their laws at this time.

A conservative estimate of nurses prepared to practice in this expanded role is 7,000. Of that number, more than 2,500 are prepared as family nurse practitioners able to provide a wide range of services to all age groups. Others are prepared in such specialties as midwifery, geriatrics, school health, Ob-Gyn. and pediatrics.

For the most part, nurse practitioners practice in clinics, HMO's and group practices and have a collaborative arrangement with a physician.

A collaborative arrangement assumes whatever cooperation is necessary in the management of a patient's health problem. It is further assumed that a nurse practitioner functioning on her own has an arrangement with one or more physicians being available for consultation, and that the nurse can refer patients easily.

> As Uwe Reinhardt, an economist at Princeton University, has observed: "If (nurse practitioners) must remain under visual supervision (or authorization) of a physician, their special and specialty distribution will necessarily parallel those of a physician, and thus permit continued existence of gaps in access to primary care."

In current practice, in most instances, the physician's signature for Medicare authorization for reimbursement is only that -- a signature. For most patients (generally 80-90% of their practice), the nurse practitioner sees, assesses and treats with no direct physician involvement.

It is important to clarify that ANA is advocating physician involvement in the delivery of primary health care by nurse practitioners. We recognize the critical necessity of appropriately delivered medical care by a physician. There is much care only a physician can deliver.

If a nurse practitioner is to provide quality care, it is imperative that a colleague relationship be developed with a physician. Where

there is overlap in services between the physician and the nurse practitioner, a mutually agreed-upon framework must be developed for the provision of joint care.

We not only support collaboration, consultation and referral between nurse practitioners and physicians, but recognize the absolute necessity of this relationship if comprehensive health care is to be provided. Nurse practitioners are ethically, legally and morally committed to the right of consumers to adequate services. The physician is the recognized expert in medical aspects of health care, the nurse in nursing aspects. The roles of each are complementary and not substitutive.

Nurse practitioners deliver care in a variety of settings including but not limited to homes, ambulatory care centers, health maintenance organizations, schools, industries and physician's offices. Statistics indicate that a large number of nurse practitioners are in rural states and the majority practice in clinics providing direct primary care.

There is no question that the nurse practitioner participates in the medical regimen of care by carrying out the appropriate medical orders of the physician and by coordinating the activities and efforts of other health personnel who participate in the patient's care at different intervals.

It also is evident that a major portion of health care includes health promotion and health education, which the professional nurse does routinely.

Many people with cardiac problems, hypertension or chronic respiratory ailments may go untreated because of a tendency to "live with" rather than seek help for early symptoms which are not acute. Nurse practitioners can make the difference in health care because they focus on early detection, health maintenance and prevention, and patient teaching and counseling.

Let me give you a few examples from my own experience:

M. W., age 70, comes into the clinic to see me for blood pressure check. Blood pressure runs about 210/120 only when the patient is not on medication properly. With this regular check, I am able to help him regulate medication and reduce his blood pressure.

Mr. D., age 67, works daily in a print shop. He will not go to the doctor because that connotes being ill, but he will come to seek care from a nurse practitioner for hypertension.

Mrs. J., age 65, has chronic leg ulcers. She became very depressed because her condition prevented her from returning to work. With the care of a nurse practitioner, she was able to have chronic leg ulcers controlled. Because the condition was controlled,

she was able to continue working long enough to be able to get her retirement benefits.

Mr. M., age 72, has hypertension and asthma. In having the availability of a nurse practitioner, the patient could get medication changed as needed. The nurse practitioner has physician contact as needed if further referral is indicated.

Mr. M., age 68, comes to the clinic for a yearly check-up. He has emphysema - a chronic respiratory condition. Frequently in the past, the patient has not come in until he had an infection. I have worked with him and his family regarding preventive care, and he now comes to the clinic before infection begins.

Though these examples relate to the elderly, my work involves patients of all ages. I would just like to mention here that I am an ANA certified family nurse practitioner.

We believe there must be a system of peer review and other quality assurance mechanisms in operation so as to evaluate effectively the care provided by nurse practitioners. Standards have been developed by the ANA for each specialty practice area, and adherence to these standards is considered essential to professional nursing practice.

In summary, the ANA does urge prompt enactment of this legislation (with certain changes), in order to continue necessary health services in underserved areas.

We do feel that this particular bill is restrictive both in services covered (medical only) and in its restriction to certain clinics, but we hope it is the first step toward appropriate reimbursement for health services wherever they are needed, rural, urban or suburban. We would like to see medicaid programs also reimburse services provided by nurses including various types of nurse practitioners and nurse midwives. Nurse midwives, geriatric nurses and pediatric nurse practitioners are providing a lot of the health services provided under TITLE XIX.

We do urge that you replace the phrase "physician extender" with "nurse practitioner and physician assistant" or "primary health care provider" as was done by the Ways and Means Committee, and that you remove the requirement of MD supervision of the RN (nurse practitioner) and replace that language with "mutually agreed upon protocols and/or in accordance with state law."

We think these changes are appropriate and do not weaken the bill. They are in keeping with the nurse's legal responsibility for her/his practice. The state nurse practice acts do guide the changing and evolving role of the professional nurse to meet society's changing health needs.

As we have pointed out, nurse practitioners are legally liable for their practice, and they do carry their own malpractice insurance.

We hope the committee will find these changes acceptable. We feel strongly that this legislation is very significant in helping to provide health care and improve continuity of health care, and we want to be able to support it all the way.

We appreciate the opportunity to appear here today and commend the committee for its attention to this significant legislation.

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STATEMENT OF DONALD W. FISHER, PH. D.

Dr. FISHER Mr. Chairman, members of the committee, I am Donald W. Fisher. I am executive director of the academy of physician assistants. I am also executive director of the association of physician assistant programs.

We greatly appreciate the opportunity to be here today to appear before you. It is quite interesting that we have been here a couple of times in the past, and we have never mentioned our really eternal appreciation to this committee; because as I review the literature I find that it was this committee in 1970 that really created the physician assistant concept and has supported it ever thereafter. So, we certainly are appreciative of that.

We are also appreciative of your efforts today to expand the medicaid program to include the reimbursement for clinic service, especially clinics in the rural areas.

I would like to ask that my full statement be submitted for the record and what I would like to do is just summarize parts of it.

I think it is important when we talk about reimbursing in rural medically underserved areas that we understand what the role of PA is, what a PA training program is, what the cost implications of this are, what this does to health access care, and what the quality of care looks like.

So what I would like to do is take a couple of minutes to talk to you about these things.

First of all, I think it is very important that you note that physician assistant is a health care provider. The practice is under the supervision and direction of a licensed physician. We now have about 44 States that have passed enabling legislation in the United States to permit this practice, and without exception they do require supervision of the services rendered by a physician assistant.

This is primarily because the PA renders medical services which heretofore have been rendered by physicians and physicians only, and we feel that supervision is necessary to insure the continuity of patient care and to assure the highest quality of care for those medical services. We have defined the role of the PA, and this is available in context and I would be glad to share it with the committee.

I think the estimates are quite accurate that a PA can do, if utilized properly, in a HMO setting about 70 percent of what a physician does on a daily basis. A lot of what a physician does also is in the realm of preventive care, and I think this is the direction we need to move toward as a country more and more in the near future.

Most PA's in this country hold baccalaureate degrees prior to entering physician assistant training programs and most have at least 3 to 5 years' experience involving direct patient care prior to entering the program. The thing also important to note of the 6,000 total PA's U.S.-wide, is that about half are practicing in towns of less than 50,000, and three-quarters of them are practicing in primary care. We have just completed a national survey, and I think it is quite interesting to note that the physician assistant concept has a migratory pattern into medically underserved areas, which exceeds that of any of the other professions we have been able to examine.

We have about 50 physician training programs currently matriculating students, a total of about 1,300 students each year, throughout the United States. About half the PA training programs are in medical schools. The other half are in colleges and junior colleges, but all of them have a formal affiliation with a health academic center. The PA programs average 24 months in length.

Since we are talking about expanding the medicaid program, we need to look at cost. Our cost data is beginning to come in now with much more regularity. It took us a year or two to reach a level that we could do some really good economic research. It also took several years before we had a critical mass of graduates working to really do some research that presented any data really worth reviewing. But we have that now. We find that it costs about one-fourth less to train a physician assistant than it does to train a physician, about a quarter of the cost for that training. I think it is also important to note if you look at physician equivalent manuals that with a physician assistant and physician starting in training at the same time, the PA can provide 2.6 years of physician equivalent service before the physician can enter into practice. Of course, that is a substantial savings also in the health care delivery system.

We have also seen data coming in now from practice settings across the country where physicians having employed a physician assistant have not increased their per-patient rate. In many areas I have talked to physicians who haven't done this, who haven't increased. I have also talked to physicians who in fact lowered their per-patient rate.

Let us look at some data coming in from HMO, and of course we realize this is different than we are discussing in medical practice, HMO settings, Kaiser-Permanete data shows that we can save approximately $20,000 per year, in that health care setting. That is a significant dollar savings, especially when we are so concerned about cost as we are today.

We have also seen reductions in hospitalization through the use of physician assistants in primary care settings, and this data is coming in now with much more frequency.

In terms of access to care, there is a wide distribution of PA's in all 50 States of the United States. As I mentioned earlier, the majority of them are located in towns of less than 50,000. And having just reviewed the data that we gathered in the last 3 or 4 months, we find that there are a significant number of physician assistants in inner-city medically underserved areas.

Quality of care is not an issue. Almost all studies—I don't know of any that don't—show that quality of care is highly favorable when provided by a physician assistant. In some specific studies, 85 percent of the patients related that the rated PA's in delivering the care was a little more competent and the PA actually provided more competent care for what they were trained in than the physician had provided, and I think that is important.

Seventy-one percent of the patients reported an improvement in care because of the physician-physician assistant interface. I think it is clear that the PA concept has really been successful, and I think it is time that we begin to recognize this a little bit more fully. If you review the available research, it shows that the physician assistant concept has

addressed three major issues concerning this Nation's health care system's problems: a reduction in cost, an improvement in access, and a delivery of high quality care. I would like to conclude with some specific recommendations for the legislation that is before you.

We, as an organization, appreciate your efforts to expand the medicaid program, in that you are really attempting to amend it by looking at the medicare program, specifically H.R. 8422.

I would like to make some comments that really relate to the payment system, definitions of a clinic, and so forth. I am sure that you will see that they relate directly to the medicaid program.

I think there is substantial agreement with the people I talked with that there is a need to expand the medicaid program, that this expansion should include cost-related reimbursement to clinics and rural medically underserved areas.

My 2 organizations were a part of the rural coalition of about 17 organizations that endorsed a number of principles that we felt were important to be considered in this health legislation.

I do have some recommendations. First, having looked at some medically underserved areas, and having traveled out into these areas personally, I find that many of these areas have few clinics, "clinics," as such—community health centers or whatever you want to call them, publicly owned clinics.

And, also I found while traveling in these medically underserved areas that there are a great number of physicians who have taken it upon themselves to help relieve this access problem in the medically underserved areas They have done this by expanding their practice, by employing physician assistants and nurse practitioners. I think for this reason we have a fear that if you don't take into account those private physicians that are delivering care in these areas, that they are not going to be encouraged to continue this extension of their practice into the medically underserved area. So, our recommendation is that the clinic as such should be defined so that a private physician's office could qualify for that reimbursement.

There are far more numbers of patients being seen today in private physicians' offices in medically underserved areas than there are in clinics, according to what definitions of clinics that I have been able to find.

I think if you are going to do this, it is important that these physicians be able to have an option to go with the cost-related reimbursement or an option to go for fee-for-service reimbursement mode.

I think we should, if our goal is to provide reimbursement for services to indigent patients, allow the physicians the option to continue the way they have in the past few years. I think we are asking a lot to get them to buy a new practitioner, to expand their practice in this way, and at the same time to expand their whole scope of reimbursement into a new system, something they don't understand, they are not familiar with. I think this opportunity for an option would allow us to obtain some more data, too. All of us are interested in cost. I feel cost reimbursement will in essence inflate or cost the Federal Government more than the traditional fee-for-service reimbursement, especially if you are considering rural areas. We need some data; an option for cost-reimbursement would provide us with a data base to compare 2 or 3

years down the road to see which is more cost efficient, to see which provides more health care for less dollars.

I know I have heard comments in the past that we can't expand, and we share the philosophy of the Congress and the Department of HEW that there are some better ways in this country to reimburse for services than a traditional service. We understand that. We support them. But we feel that an option is important so we can allow transition, if you will, into a new system. We don't believe that fee-for-service reimbursement to medicaid patients or medicare patients in medically underserved areas would lead to fraud and abuse. And I have heard that, as I have dealt with this issue for many years now, if a person is going to be taking advantage of the Federal reimbursement programs he or she is going to do it whether he or she has a PA or has reimbursement or not.

Mr. FLORIO. Dr. Fisher, I am going to have to interrupt you at this time. The bells have rung, and what we are going to do is take a 10-minute recess, go vote, and then come back.

[Brief recess.]

Mr. FLORIO. If we could proceed.

Mr. Preyer offers his opologies. He has two other meetings. That is a common failing around here.

Proceed, Dr. Fisher.

Dr. FISHER. I just have a couple more recommendations.

One recommendation relates to physician supervision. We feel that physician supervision and review of the activities of physician assistants and nurse practitioners should be required, but limited to medical functions. We don't think that supervision should require the immediate presence of the physician.

I also would like to recommend that the definition for rural that is in Senator Clark's bill, S. 708, be the one that would be used by this medicaid bill, and we are also making that recommendation to H.R. 8422 in that it should be defined as nonurbanized areas, the 50,000 population or less. One other recommendation we have is that we would like to see the words "physician assistant" and "nurse practitioner" substituted for physician extender and also substituted for primary health care practitioner. We would like to see the terms that have become almost definable now in the States across the United States, physician assistant and nurse practitioner.

We would like not to have to get in and redefine some new terms. We feel physician assistants should be certified by the National Commission on Certification of Physician's Assistants to be eligible for the reimbursement, and nurse practitioners should be certified by the Nurse Practitioners Association, or by NCCPA which is the National Commission on Certification of Physician's Assistants of which they have the option.

I have some data on costs of what we expect that this might cost medicare and medicaid programs. I would be glad to submit this to you for the committee's consideration at a later date. I certainly appreciate the opportunity to be here to speak and again want to thank you for the support this committee has given for PA's

Thank you.

Mr. FLORIO. Without objection, both statements will be entered in the record in full as well as supplementary materials you may desire to submit to the committee.

[Testimony resumes on p. 82.]

[Dr. Fisher's prepared statement follows:]

STATEMENT
TO THE
SUBCOMMITTEE ON HEALTH & THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

BY THE AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS
ON
REIMBURSEMENT OF RURAL HEALTH SERVICES UNDER THE MEDICAID PROGRAM
July 29, 1977

I am Donald W. Fisher, Ph.D., Executive Director of the American Academy of Physicians' Assistants and the Association of Physician Assistant Programs. I appreciate this opportunity to share with you my concerns about the provisions of health care to citizens living in rural and medically underserved areas throughout the United States.

The Physician Assistant profession shares with the Congress its concern over the ever-increasing cost of delivering health services to the people of this nation. We are equally concerned about and committed to the provision of primary health services that are easily accessible to the aged and medically deprived populations in our rural towns and urban centers.

We believe that the utilization of physician assistants by qualified physicians can help slow the spiraling cost of medical care, while extending the access of care to more people than ever before. In fact, our literature is replete with articles testifying to the many benefits of PA utilization in various parts of the country. However, one major stumbling block still exists that is delaying the optimum utilization of physician assistants, and that is the lack of Medicare and Medicaid reimbursement for services rendered by physician assistants.

MEDICAL CARE AND THE PHYSICIAN ASSISTANT IN THE UNITED STATES

The United States Congress has, in the past six years, actively promoted the training and development of physician assistants (PAs). The Comprehensive Health Manpower Training Act of 1970 was responsible for the development of 42 physician assistant training programs whose graduates would assist primary care physicians by providing routine medical and health care services in underserved areas. The Health Professions Educational Assistance Act of 1976 authorized continuation of federal support for physician assistant programs. It should be pointed out that the U.S. Department of HEW has funded physician assistant training

and research to an amount over 48 million dollars.

The Congressional support, cited above, coupled with organized medicine's recognition of the need for formally trained assistants, has been responsible for the training and development of physician assistants. In 1970, the American Medical Association defined the physician assistant as "...a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." In 1971, Educational Essentials[1] were jointly developed by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Physicians' Assistants, and the American Society of Internal Medicine. Through this accreditation mechanism, more than 50 programs have been accredited to date. In 1973, the National Board of Medical Examiners administered National Certifying Examinations and continues to do so under the auspices of the National Commission on Certification of Physician's Assistants. Over 40 states have enacted legislation providing for the practice of physician assistants with legislation currently proposed or pending in the remaining states. In 1973, the Secretary's Commission on Malpractice stated that the then growing concern over malpractice should not be a deterrent to the utilization of physician assistants.

PHYSICIAN ASSISTANT IMPACT

Economics of Care:

Educational cost data from the National Center of Health Services Research (NCHSR) on physician assistants show the education cost to be 15,100 dollars per year.[2] The cost of producing a physician assistant is less than 1/4 that of preparation of a graduate physician.[3] Wert's[4] data shows that a PA can provide 2.6 years of physician equivalent services before a physician who simultaneously began his medical education can begin practice. Moreover, Record[5] estimates a saving of $20,000/PA/year in an HMO setting. Peterson[6] and his colleagues have shown very significant reductions in hospitalizations through the use of PA staffed ambulatory care clinics in a major VA hospital.

Access to Care:

Record[7] and Hill[8] in separate studies have shown that the outputs of primary care services are similar for both physicians and physician assistants. Moreover,

Scheffler[9] and Fisher[10] report wide distribution of PAs throughout all 50 states with a majority of PAs in primary care settings. Sixty (60) percent of PAs are in communities of less than 50,000. For example, in Oklahoma, 62.2% of program graduates are in communities of less than 25,000; in Utah, 72% of program graduates are in communities of less than 25,000, and in Washington, 57.7% in communities of less than 20,000. Also, significant numbers of physician assistants are working in inner city areas. The recent health manpower legislation not only authorizes funds for physician assistant training and National Health Service Corps Scholarships, but also requires that part of each Area Health Education Center include training for physician assistants or nurse practitioners. Also, it appears that the Health Resources Administration has decided that new funding for these centers will be directed at inner city urban areas.

Quality of Care:

Numerous studies, Nelson,[11] Pondy,[12] Henry[13] and Norbrega[14] have shown that job acceptance, as a function of quality, is highly favorable. For example, Nelson found that more than 85% of patients rate PAs as highly competent and professional, and 71% report improvement in the quality of care. Record reports no significant differences in morbidities or outcomes in primary care services delivered by MDs and PAs. More importantly, B.J. Anderson, J.D. (Staff, American Medical Association Legal Council) stated that as a result of decreased waiting time, increased accessibility to professional care and overall patient satisfaction, it appeared that the inclusion of a physician assistant in a practice was an excellent deterrent to the ever present threat of malpractice.

IN SUM, A REVIEW OF AVAILABLE RESEARCH SHOWS THAT THE PHYSICIAN ASSISTANT CONCEPT HAS BEEN SUCCESSFUL IN ADDRESSING THE THREE MAJOR ISSUES CONFRONTING THE NATION'S SYSTEM FOR HEALTH CARE: (1) A REDUCTION IN COST, (2) AN IMPROVEMENT IN ACCESS, AND (3) THE DELIVERY OF HIGH QUALITY CARE.

THE IMPEDIMENT: MEDICARE, PART B

In spite of evidence that the physician assistant concept has been successfully addressing major national health problems, further deployment of physician assistants into underserved areas is being seriously impeded by the current Medicare Law (Title XVIII (Section 1861 (s)(2)(A)), its rules and regulations, as we testified before the Senate Finance Subcommittee on Health on July 21, 1977.

Excerpts from the Medicare Act and Part B. Intermediary Manual reveal the problem:

> Title XVIII Sec. 1861 (s): "The term 'Medical and Other Services' means any of the following items or services...(2)(A) Services and Supplies...furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physician's offices and are commonly either rendered without charge or included in the physician's bills...."
>
> Part B Intermediary Manual, Sec. 6103 (B): "...there is no provision under Part B which authorizes coverage of the services of physician assistants as independent practitioners, the only basis for covering their services under Part B would be as services furnished incident to' a physician's professional service and one of the...requirements... for services to be covered under this provision is that they must be of kinds that are 'commonly furnished' in physicians' offices. Thus, the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met."

The current attention drawn to the "non-reimbursement" policy has had negative impacts in rural underserved areas of this nation. Without reimbursement for services performed by physician assistants practicing in areas with large numbers of Medicare recipients, physicians cannot afford to employ a physician assistant even though the potential benefits to patients are well recognized. Physicians have had to sharply curtail the utilization of their PAs when Medicare would not reimburse the employing physician for their services. Many program directors fear that their graduates will be forced into affluent suburban or institutional practices because the employing physician cannot be reimbursed for services safely and legally delegated. Most importantly, many Medicare recipients are having to pay for the delegated services out of their meager incomes.

In summary, in the past decade, we have seen the development of a new health profession with an accreditation mechanism which is recognized by the Office of Education (DHEW); certification mechanisms through the National Commission on Certification of Physician's Assistants and legislation in 43 states granting

statutory recognition for this profession. The evidence exists that physician assistants may reduce the physician's risk of medical negligence by improving the continuity of care. Research does exist which confirms excellent patient acceptance of physician assistants, that physician assistants are improving access to health care by practicing in geographical areas deficient in health manpower, physician assistant productivity - within their role - is comparable to physician productivities, and that the potential for reducing the cost of health care is present with the utilization of physician assistants.

RECOMMENDATIONS

Mr. Chairman, we fully support your efforts to expand the Medicaid programs to include reimbursement to clinics located in rural medically underserved areas. In that HR 8543 is an amendment to HR 8422 which establishes section 1833 (A)(3) of Title XVIII, we would like to make several comments and recommendations which specifically impact on the proposed expansion of the Medicaid Program (HR 8543).

It seems to me that there is substantial agreement that the permanent expansion of the Medicare and Medicaid program should include cost-related reimbursement to clinics located in rural, medically underserved areas, in order to cover the health care services of physician assistants and nurse practitioners.

If the basic objective of HR 8543 and HR 8422 is to make health services more available to medically-needy citizens provided that over-utilization of health services and program abuse is not enlarged upon, we feel several changes are in order.

First, many medically underserved rural and urban areas have few "clinics" as such -- community health centers that are publicly owned and operated. Many physicians have responded to the access problem in small communities and urban settings by utilizing physician assistants and nurse practitioners to provide care for the residents of these underserved areas. It is our fear that this trend of physicians providing increased access to care by utilizing physician assistants and nurse practitioners in these areas will be discouraged in the future if these physicians cannot be included in the definition of clinic and if they do not have the option to receive cost-related reimbursement or fee-for-service reimbursement for the services of their physician assistants or nurse practitioners. We understand

the preference of many members of Congress and of the Department of Health, Education and Welfare to move in the direction of a prospective, cost-related or capitation approach. However, if your objective is to respond to the geographic imbalance of health services, the important role played by the private physician should not be ignored. We recommend that Congress define "clinic" in such a way that private physicians in rural and urban medically underserved areas be eligible for reimbursement for the services of the physician assistant and nurse practitioner they employ. Further, we recommend that specific language be added to HR 8543 or HR 8422 to allow these physicians an option to choose cost reimbursement reasonably related to providing the covered services or fee-for-service reimbursement. The reimbursement rate for the fee-for-service option should be equivalent to the physician's usual and customary rate. Physicians that select this option over the cost-related clinic reimbursement should not be permitted to employ more than two physician assistants or nurse practitioners.

Second, we firmly believe that physician supervision and review of the activities of physician assistants or nurse practitioners should be required and limited to medical services. Supervision should not require the presence of a physician, but should entail the preparation of written protocols for medical care and treatment that are mutually agreed upon by the supervising physician and the physician assistant or nurse practitioner.

Lastly, we believe that the term "primary care practitioner" in HR 8422 should be replaced with physician assistant and nurse practitioner. Physician assistants should be certified by the National Commission on Certification of Physician's Assistants, and nurse practitioners should be certified by either the National Commission on Certification of Physician's Assistants or the American Nurses' Association. The Secretary of HEW should review the certification requirements one year from the date of passage and, if necessary to insure high quality health care, set new standards of eligibility. Reimbursement should be permitted prior to full certification in states where services may be provided in this structure.

Thank you very much for this opportunity to present my views on this subject. I hope you and your staff will call on me for any assistance I may provide.

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Mr. FLORIO. I have some questions I would like to ask but rather than begin them and then go vote I will vote now and be back as soon as possible.

[Brief recess.]

Mr. FLORIO. Ladies and gentlemen, I would like to reconvene the hearing.

Just for everyone's information, what is happening is that we are having a series of votes this morning. It may be a little disruptive.

I have a couple of questions I would like to ask and will make them brief, perhaps more so than I would have liked.

You stated, Doctor, the degree of supervision should be confined only to medical functions. As defined by whom?

Dr. FISHER. Well, I think in many of the practices there are established written protocol and procedures. I think that needs to be defined co-jointly between the physician, nurse practitioner and the physician.

Mr. FLORIO. On a State basis or——

Dr. FISHER. As far as PA's are concerned, many of these are being defined on a State basis. The type of rules that are being promulgated are such that the State medical board actually sits down and defines those things which PA's cannot do and can do in some instances, and, of course, that is statewide.

Mr. FLORIO. When we get a State medical board defining it, that is really not conducive to negotiation of any sort, is it?

Dr. FISHER. Well, it is such a new concept and so few PA's are out practicing in States where it is actually negotiated—in many cases these are promulgated in public hearings. The physician nurse practitioner and physician team will come into the office of the State medical board and actually discuss these rules and regulations, so there is a lot of input by the practitioners. Then they have been amended and do finally get amended on a regular basis.

Mr. FLORIO. With regard to both areas, nurse practitioner and physician assistant, what percentage of both specialties or both professions currently are involved in working in a hospital setting? Do you have any substantial percentage of you people working in a clinical setting?

Dr. FISHER. I don't for nurse practitioners; maybe they do.

Mrs. MULLINIX. I can speak very specifically for my State. I would say less than 10 percent are working in hospitals within North Carolina. Now, within the hospitals that also includes outpatient departments so they are primarily giving primary care—very few in hospitals.

Dr. FISHER. I would say for PA's nationwide our data indicates that between 10 and 13 percent are employed by hospitals. Our recent data indicated about 39 percent of physician assistants have privileges in hospitals, so they can actually go around and take care of patients in hospitals.

Mr. FLORIO. You say the balance of physician assistants are actually employed in doctors' offices?

Dr. FISHER. That is correct.

Mr. FLORIO. So there would be very few, if any?

Dr. FISHER. Very few.

Mr. FLORIO. In true clinic settings as of now?

Dr. FISHER. That is correct.

Mr. FLORIO. I would like to comment on a statement you made about the cost of a physician's assistant being approximately one cost. The cost is believed to be approximately one quarter of the cost of the training of a physician. I wonder if in fact that is misleading in terms of the ultimate benefits to be derived for society. One of the deficiencies involved with cost containment in preventive health is insufficient medical education. The physician extender service may be involved in that medical educational component of the health delivery service, thereby, putting more time in utilizing this service. That time would, of course, be made up with the reduced cost.

But I don't think we should hold out these specialities as being cost saving in the absolute dollars it may very well be that we are going to get more health benefits for our health dollar, but I figured it would be misleading to say that by adopting greater emphasis upon the extender concept that we are talking about reductions in dollars.

Am I striking any kind of a responsive cord?

Ms. HOLLERAN. I would like to speak on that and say that we agree there has been a lot of pressure in the evaluation studies being done, on the number of patients being seen in so many minutes, and with the kinds of teaching and prevention and that kind of primary care that we think is being denied people in the present system, an overemphasis on cost could be harmful.

Mrs. MULLINIX. I would also like to add that the doctor with whom I work and I think our clients get better care from both of us rather than either singly. The patients gets more of my time, preventive services and monitoring; when they need the specialized care of the M.D. they see the Doc. With this arrangement, we are able to see more patients.

Mr. FLORIO. I see. You made reference to your inner-city experience, and there seems to be a number of physicians assistants in the inner city. The more we go through the bill, the more we find out that the problems that are common to rural areas are also common to the inner-cities. Malnutrition and lack of health education facilities are a few examples. I am starting to question the rationale for even dealing with this problem on a rural basis. If there is a common problem why not deal with it on a rural as well as an inner-city basis? Are there any specific problems not common to the inner city ghetto, which would justify treating the problem only on a rural basis?

Mrs. MULLINIX. We would very much like to have services for all people.

Dr. FISHER. Yes, I might point out that we are very strong advocates of not just limiting this to rural. We would like to see as much of it urbanized as possible. We see that some of the data coming in is that a person in the inner-city area who does not have access to care, would use the emergency room; and if they bill for this service, that is quite expensive, and you are paying a lot more for that emergency room service than if the clinic or privately supported office were used. We support that.

Mr. FLORIO. We talk about reimbursement in medically underserved areas. We suggest the need for option cost related reimbursement as well as a fee for service. If we are going to talk about cost

containment which is very important and absolutely essential in terms of dealing with the health problems of the nation, cost-related reimbursement seems to me one of the big breakthroughs. I am just not sure adopting a fee-for-service concept in the clinical setting is desirable. You stated that physicians might find it difficult to comprehend or adjust to cost-related reimbursement.

I find that very difficult to accept. I think that they are going to be able to get used to it and certainly be able to understand it without any difficulty. I would just like a bit of thought from both of you as to whether a clinical setting on a fee-for-service basis would really go towards maximizing the health benefit for the health dollar investment. Also, would it try to contain costs in a more cost effective way by utilizing the extenders in the most cost effective manner that they can be utilized?

Mrs. MULLINIX. I think in some of our rural areas you are really talking about everybody needing care and not being able to get it. And what we would like to urge is that we look at outcome, therefore we are talking about that this service is delivered. And you can reimburse for just that service, not tying it directly to the person that gives it.

It is the clinics that are going to be closing, for example, the ones in North Carolina. We have some in Hot Springs, N.C. right now where someone will come into the clinic and want to receive care. My nurse practitioner friend Cathy says, "Why don't you come back on Tuesday because then the doctor will be here and then you can get reimbursed."

Dr. FISHER. On the fee-for-service option, I think what we are dealing with is our thrust to provide services to patients. Whether the clinics are closing, or private physician offices are closing, that has a very, very real bearing on the services being rendered to patients. What we have looked at is what does it cost?

If we are going to provide service to patients in private physician's office and if they went with fee-for-service mode, which is what they are doing right now, our estimate is it would cost about $1 million for the first year.

Now, that is not an awful lot of money, and that is under the medicare program. Under the medicaid it would be substantially less Federal dollars because of the State picking it up as well. This is based on figures that come out of HEW that if you figure in the physician's income, you figure in the number of medicare patients that they see, if you look at the increased intensity of care for older people, and the deductibles, if you take all these things in consideration, the cost for medicare reimbursement under fee-for-service mode is $1,728 per physician assistant-physician team, per year.

There are 5,000 PA's out here in the country. That is $8.9 million. All of them aren't practicing in areas which we are talking about for reimbursement, so we take half of them and we are down to half that amount of money. If you look at the fact that already in this country 3 out of 4 of those practitioners are being reimbursed under medicare and medicaid, without the explicit guidelines to quality in there that we would like to see it, you are talking about three-quarters of that money already being paid for, so you are down to $1 million.

What are are talking about is a demonstration just to make sure that we have a transition into a new mode of reimbursement to allow a physician an option to go either way. I would think that for a physician in a rural medically underserved area it would be most effective for them cost-wise, and I guess a majority would choose cost-reimbursement, but we would like to have the experience to continue the fee-for-service mode so we have some comparative data.

What are we going to compare the cost for service to in order to show and answer questions you are raising? We would then be comparing apples to oranges.

Mr. FLORIO. We have had a fee-for-service mechanism on line straight on through. What you are going to say is convert the doctor's office into a clinical setting.

Now, I am just not sure how we are going to do that. If a doctor's office is labeled a clinic then the procedure of reimbursement through fee-for-service would continue.

I am not accusing them, but we are almost making a sham out of the changes. We are not doing anything. We are providing a physician with an opportunity to call himself something else, to qualify for a new program. I don't think we are making any changes by labeling a doctor's office something it is not. I really don't foresee any changes, any sense of outreach which is the whole rationale for this bill.

And I would just like to conclude on your thoughts with regard to a concept of having a clinic submit in advance its budget for a period of time, which of course would be approved, hopefully would be approved, and then have reimbursement in accordance with the approved budget.

In a sense I suppose we are talking almost HMO philosophy, but do you find that this could be incorporated into this type of approach?

Mrs. MULLINIX. I have no problems with that at all. It sounds like there would be funding for the clinics, we are talking about, that the services could be provided, and I think it would avoid a lot of problems that we are discussing now.

Another part of that is I should think that then the preventive part of it would be included so that we would be taking a step forward.

Mr. FLORIO. Just on the question of a fee-for-service, if the fee-for-service was given in your example to the doctor's office, who would get the fee? How would the breakdown go between the physician versus the physician extender? Would that be left for negotiations between the physician extender and the physician?

Dr. FISHER. We would request that the fee go to the physician, to the practice, not to the physician assistant, not to the provider.

Mr. FLORIO. Do you concur with that?

Mrs. MULLINIX. Well, I think that is the way it is right now.

Mr. FLORIO. I see no difference between the existing systems.

Dr. FISHER. But there is a difference. The difference is that under the current existing system a physician cannot get reimbursed for those services rendered if that physician is not immediately present when the service is rendered or not incident to that service.

Mr. FLORIO. You state that the physician cannot get reimbursement?

Dr. FISHER. That is correct, if the service is rendered by the physician assistant and the physician upstairs or in a different room or another site they cannot get reimbursed.

Mr. FLORIO. What you are saying is the physician can get the money, he can still be upstairs or anyplace else, but he is still going to have to sign off, because the money would be paid to him, under your suggestion.

Dr. FISHER. That is right.

Mr. FLORIO. I understand what you are saying. I am just not sure that we are doing anything substantively different. Under the proposal we are calling something a clinic and we are going to have a physician who is not present, mandate the money to be paid to him. We certainly are not doing anything to enhance the importance or the symbolic significance of your professions. We are still going to go through the same procedure that we have now.

I am not sure that it is in accordance with what I hope is the philosophy of this bill. I believe the philosophy is to update the caliber and importance of what your mutual professions are going to provide. Also the philosophy of the bill is to get some outreach by authorizing the clinics to go out into the community in order to make the services available. I have some serious reservations with regard to the suggestions you are making.

Dr. FISHER. Well, we agree with what your intent is an what you are trying to do, and of course one of my recommendations is that the physician's practice be eligible to qualify as a clinic and I haven't seen that sufficiently expressed in the language of either of the bills to really assure that that option would be available to the physician's practice. This is only one of our recommendations.

Mr. FLORIO. My own opinion is probably not in keeping with the philosophy and would not be achieving what the bill would be designed to achieve, but there are other members on the committee besides myself.

I want to thank you for providing very good testimony and for providing very good responses to the questions. It has been very helpful to the committee.

Dr. FISHER. Thank you.

Mrs. MULLINIX. Thank you.

Mr. FLORIO. Mrs. Lubic, as well as Mrs. Kitty Ernst, are the next panel that we have.

Good morning.

Thank you very much for your patience.

Whoever desires to may proceed.

STATEMENTS OF RUTH WATSON LUBIC, C.N.M., GENERAL DIRECTOR, MATERNITY CENTER ASSOCIATION; AND KITTY ERNST, C.N.M., M.P.H., PAST PRESIDENT, AMERICAN COLLEGE OF NURSE MIDWIFERY

Mrs. LUBIC. Representative Florio, members of the subcommittee, my name is Ruth Watson Lubic. I am a charter member of the Institute of Medicine of the National Academy of Sciences. I am also

a nurse-midwife and the chief executive of a national voluntary health agency, Maternity Center Association, whose first director was Frances Perkins.

Mr. FLORIO. I have read of her.

Mrs. LUBIC. MCA has an overriding goal of improving maternity care. It has pursued this goal, for example, through establishing in 1917 the first prenatal care centers; in 1931, the first school of nurse-midwifery in the United States; in 1948, the first prepared childbirth program—in conjunction with the Yale Medical School. Parallel to these specific endeavors have been our continuing efforts in health education through the publication of materials for both the public and professionals.

I am going to talk with you today about a new model in family centered maternity care that we have developed because I think it will explain why we are here to testify in behalf of nurse-midwifery.

Eunice K. M. Ernst, who appears with me, is a consultant in nurse-midwifery who was prepared at the rural Frontier Nursing Service and knows it well. We thought that between us we could possibly elaborate on what nurse-midwifery might be able to accomplish if included as part of this bill.

We feel that because nurse-midwifery in the United States is more than 50 years old it has a different evolutionary pattern than the current nurse practitioner movement, which has surfaced mainly over the last 10 years. We have developed our own professional association, dating from 1955. Our certification occurs in a different manner than through the American Nurses Association. We should also note that there is a nurse practitioner in obstetrics and gynecology whose function differs from that of the nurse-midwife in the sense that she does not perform delivery services. We would hope that these two different kinds of health professionals would not be confused in the bill.

The assumption is often made, I believe, that attendance in delivery—that is, what we would term intrapartum care—is not primary care; but in our estimation it is, because we deal with the normal parturient in all phases of her maternity cycle. We definitely do consider labor and delivery to be part of the primary care experience of families.

We operate in a team situation as experts in the normal. We have well-defined educational programs. Our functions and standards of qualifications are elaborated within the profession and in the team setting. I could not help thinking of that when you asked how the functions of the physician's assistant would be decided.

Let me move to the demonstration program that we are currently conducting, because I think it will indicate how nurse-midwives—at least those who are a part of this concept—deal with many of the questions that you have raised. Our model was actually developed in response to public dissatisfaction with in-hospital maternity services. Although it is located in New York City, the model can serve in either urban or rural areas.

The childbearing center, as we call it, is based on a nurse-midwife obstetrician team. The cost of care is one-third to one-half that of in-hospital care in New York. The total fee is about $750. Physicians are

employed by the center as consultants. They aren't present when delivery is taking place unless the nurse-midwife feels that she needs their consultation and support.

Families are encouraged to be responsible for their own health care as rapidly as they can. We look on this kind of primary care setting as a maxihome, if you will, and not a minihospital. Through a very extensive educational program, we are trying to get preventive care centered in the home and in the families where it really belongs, with professionals offering support.

We could take a very quick position on fee for service. We are not in favor of that idea at all. As a matter of fact, in setting up the model, Maternity Center has taken the position that it is not enough simply to cut up the health-cost pie into different segments for different types of practitioners, but rather we need to try to shrink the pie. And that is what we are trying to do. Blue Cross-Blue Shield has been very helpful to us in that they do reimburse the families coming to us for care, and all private insurers have followed suit.

With regard to medicaid, New York State approved us for reimbursement, but the city of New York, on the advice of its obstetrical advisory committee, has not provided us with a medicaid vendor number, so our care has not been generally available to low-income families.

Mr. FLORIO. If you don't mind, I will go vote and come right back.

[Brief recess.]

Mr. FLORIO. If we could proceed.

Mrs. LUBIC. I was just going to add one or two things, Representative Florio, before deferring to Mrs. Ernst.

In terms of supervision and control, we feel that in our model it is a team control. It is, of course, dependent upon having expert obstetrical backup. However, the team for us is more than the obstetrician and nurse-midwife and the public health nurse who provides followup care in the home. It consists very much of the families as members of the team.

In other words, there is a strong input from families. With this in mind, I would urge you to consider in any of your future deliberations that, while there should be direct payment to a health agency, perhaps it should be a nonprofit agency, with a board of directors that has strong representation from consumers.

I think one of the reasons that our costs can be less than they are elsewhere is that we really try to emphasize a natural approach to childbearing, so we avoid the use of high technology. As a matter of fact, it would be inappropriate in our setting.

Another reason that we can be less costly is that the services are evaluated from the point of view of whether or not they satisfy families rather than professionals. If we don't satisfy those families that we are trying to bring in from do-it-yourself home delivery, we are not going to have anyone coming to us at all. Families feel that we are offering an improvement in care, because they do have input and because there is no routine intervention in their childbearing experience.

I think it is fair to say that if, for example, we replaced all our nurse-midwives with physicians in the same out-of-hospital setting,

the care would be a lot more expensive. Physicians tend to want to utilize their skills, which is perfectly understandable. So there is no question in my mind that improved care can be provided, and at lower cost.

I think your comment that we would get more for our health dollar in offering preventive services is very apt, and our model proves that that is the case, in my estimation.

Mr. FLORIO. Would it be fair to say that your clinic, inasmuch as you presently don't have medicaid reimbursement, relies on either direct payment or on individuals with Blue Cross-Blue Shield programs. Essentially, you are not largely dealing with lower income people, but would be dealing for the most part with middle-income people?

Mrs. LUBIC. We do see a spectrum of families, but I think the majority we see are middle-income people. And this is a result of the fact that when medicaid-eligible families are interested in our care, we have to tell them that we are not able to secure medicaid reimbursement, and we try to refer them to other services. But we do this with great regret.

We have been fighting for that medicaid vendor number since November 1975. The obstetrical profession in New York City took an a priori position that we are not safe, and even after having proved our safety since then, in the opinion of expert committees and also of the New York State Health Department, which has looked very carefully at our data, we still have not received the medicaid vendor number. That situation will probably become moot by the end of September, because the State of New York has canceled its medicaid contract with the city of New York, but when you talk about barriers to improvement of care it has been poignant for us.

Mr. FLORIO. The passage of this legislation, should it be modified so as to specifically include your type of facility, I assume it would also alleviate the problem.

Mrs. LUBIC. Yes, I think so, although I really think that what has happened to us is we have been caught in a city-State fight, although the State has been very supportive.

Mr. FLORIO. Yes.

[Mrs. Lubic's prepared statement follows:]

STATEMENT OF MATERNITY CENTER ASSOCIATION

48 East 92nd Street
New York, New York

Ruth Watson Lubic, General Director

RE: HOUSE BILL 8422 BEFORE THE SUBCOMMITTEE ON HEALTH & ENVIRONMENT

July 29, 1977

My name is Ruth Watson Lubic. I am a charter member of the Institute of Medicine of the National Academy of Sciences. I am also a nurse-midwife, and the chief executive of a national voluntary health agency, Maternity Center Association, whose first director was Frances Perkins (for those of you who might remember). MCA has an overriding goal of improving maternity care. It has pursued this goal through, for example, establishing in 1917 the first prenatal care centers; in 1931, the first school of nurse-midwifery in the U.S.; in 1948, the first prepared childbirth program (in conjunction with the Yale Medical School.) Overarching these specific endeavors have been our continuing efforts in health education and prevention--the publication of materials for both the public and professionals.

Eunice K. M. Ernst, who is testifying with me, is a consultant in nurse-midwifery, well known to MCA, who was prepared at the rural Frontier Nursing Service and knows it well. In consideration of your crowded schedule, we will testify jointly.

In commenting on HR 8422 we urge you to specifically mention nurse-midwives because of their history of effective practice in both rural and urban areas and because of the public's demand for our services today.

What is a nurse-midwife? The American College of Nurse-Midwives defines the concept as follows: "The nurse-midwife is a Registered Nurse who by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, has extended the limits of her practice into the area of management of care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal."

Maternity and Infant Care projects and other programs have reinforced the acknowledged value of nurse-midwives in serving low-income families. We have seen, for example, the dramatic results demonstrated in the Mississippi Delta by the County Health Improvement Program, where infant deaths declined from a national high of 39.1 per 1,000 live births to 21.3 in just three years. This success led to the creation of the Southeastern Regional Council on Development of Nurse-Midwifery, whose goal is to begin or expand nurse-midwifery services throughout the six states of the region. Impressive results have also been achieved in many other settings such as Madera County, California.

Childbearing today is in a very fluid state. Nowhere are women more aware of and less patient with the "system" than in the field of their own reproductive functioning. Disenchantment with available services is demonstrated by the women's clinics which have grown up in many rural and urban areas, most often to provide gynecologic and fertility control assistance. But perhaps a more dramatic response is seen in maternity care in the return to home deliveries, with or without professional assistance. This return, most prevalent on the West Coast, is widely documented in the media.

At first glance, it may seem paradoxical that awareness of health would lead away from institutionalized maternity care rather than toward it. But, as young people have informed themselves about childbirth, they have recognized its inherent normalcy and demanded a cooperative role in planning care. Routinized hospital practices have been illuminated as the ritual they often are.

Nurse-Midwifery is being increasingly sought to provide an answer to this public health dilemma because, I believe, education of mothers and families is the soul of nurse-midwifery practice, a dimension which causes it to differ qualitatively from an obstetrical approach to childbearing women. This fact, tied to the expertise of the nurse-midwife in the normal childbearing process, means that she has tended to be health oriented, not pathology oriented. These two facts, tied to her ability to teach the theoretical aspects of childbearing and rearing, and also provide practical suggestions in on-the-spot clinical situations, enhance her educational effectiveness.

But, more important, in my opinion, nurse-midwifery management of the entire childbearing experience offers an unusual opportunity for establishment of trust between care receivers and care givers. In this manner the validity and acceptance of teaching, which at times can be only theoretical and not applied until a future time, are ensured. Nurse-midwives, then, are with a family through one of its most exciting and gratifying life cycle events, sharing in the joy at the climax of the reproductive miracle as well as being supportive through the days of expectation and the trials of settling a newborn into the family.

Second, maternity care is prototypical preventive health care and, therefore a natural entry point for providing the information that women and families are seeking. It has always been our experience at Maternity Center that families involved in the childbearing experience are eager for other health care information. "Lack of patient motivation," a phrase we professionals often use when our health teaching is ineffectual, is seldom a problem in prenatal classes which are meticulously attuned to the interests and needs of families. But looked at from the point of the needs of the health care delivery system as well as the grass roots needs of families, what can nurse-midwives do? Are they sensitive to the "big picture"?

In 1973, Maternity Center Associa tion, through nurse-midwifery leadership, put into effect a new kind of pragmatism in the maternity care field. We took complaints of the "opting out" families, those involved in unattended home birth, cast them against a screen of the fears of professionals and designed an alternative which we felt would meet the needs of all concerned, either individually or societally. Therefore, we developed a plan for safe, satisfying and economic maternity care which utilizes both the best of past experience and current scientific and health planning theory. It does this through rigorously screening the families to insure that they are proper candidates for care in our demonstration,

the Childbearing Center. The Center opened in September of 1975 after more than two years of scrutiny by the New York State Public Health Council, including its advisory bodies, The Health and Hospitals Planning Council of Southern New York, The Comprehensive Health Planning Agency of New York City, and The New York State Hospital Review Council. Dr. Seymour Romney of the Albert Einstein College of Medicine's Department of Gynecology and Obstetrics and its former chairman, has recently written the following:

> "The Maternity Center Association, which has been responsible for significant innovations in maternity care in this country is currently running a delivery service in an "out-of-hospital" maternity unit. After a year's experience, the program has unequivocally established the fact that safe, more personal, compassionate, maternity care can be offered more economically than in the hospital. In part designed to examine an alternative to a growing inclination on the part of many younger people to have births at home in a non-safe setting, the Maternity Center has carefully developed criteria for screening pregnant women for admission to the program. Once voluntarily enrolled in the program, patients are constantly monitored and evaluated as to maternal and fetal health status. Arrangements and criteria exist for contingency transfer of any patient to an accredited back up hospital. The husbands incidentally have been incorporated in many aspects of the comprehensive care."

What are the essentials to the success of the demonstration? Basic to the success is the utilization of a health care team which ensures the achievement of all three goals: safety, satisfaction, and economy.

At the heart of the team are nurse-midwives, functioning with the consultation, support and assistance of physicians, both obstetric and pediatric, nurse-midwife assistants and public health nurses. The input of the families themselves is the sine qua non of the team's functioning.

The utilization of nurse-midwives ensures the economy of the Childbearing Center. Our fee represents cost and is one-third to one-half of the fees (not necessarily the costs) at medical centers nearby. For example, private care at one tertiary unit costs a family $1300 for in-hospital services including a 2-day postpartum stay, $700 for the obstetrician's delivery fee and $30 for each prenatal and postpartum visit. This total $2300+ is for a perfectly normal delivery--no extras. The costs to Medicaid in New York for a normal delivery are considered to be $2000 with, at another nearby hospital of secondary level, a per diem of $205 for mother and/or infant in intensive care. The per diem for normal nursery care is one-third the $205 figure, or about $70. That's a baseline of $275 per normal postpartum day. Obstetrical fees and prenatal care would be added on and bring the total to the $2000 figure.

The complete cost of care at the Childbearing Center is $750 and includes full prenatal care with at minimum two of the visits by one of our staff physicians, a pediatric exam for the infant, public health nurse follow-up in the home on days one and three to five, and all return visits. It also includes intensive prenatal education. Because families go home in up to twelve hours following delivery, their instruction emphasizes the care of a newborn and is designed to build their confidence in providing such care. While in the Center, parents and infant are never separated. We have been approved by New York State for Medicaid reimbursement and all private insurors, including Blue Cross, cover our families.

Essential also to its economy is the CbC's placement out of high cost hospital space. A back-up hospital for problems is essential, but normal childbirth does not need hospital facilities. We do keep safety measures such as intravenous capability, oxygen, emergency drugs, infant resuscitation equipment, and infant warmer and a transfer isolette.

Our best safety factor is the nurse-midwife and her adherence to the criteria drawn up by the team. For the nurse-midwife's proven expertise is in the management of the normal and if there is any question of deviation therefrom, we transfer immediately. Deliveries are performed by nurse-midwives with the qualified physician available by telephone for consultation or in house if summoned.

Requests for information in order to replicate our setting overwhelm us. Always the reimbursement question is asked and most often it must be negatively answered. (New York is an exception), even though nurse-miwifery has been alive in both rural and urban areas in the United States for over 50 years.

Two long term experiences in the U.S.: that of the Frontier Nursing Service and, MCA's (1931-58) are well reported in the literature. They demonstrated results better than the country as a whole. Both services utilized nurse-midwives as the primary care-givers. MCA's experience matched in 1958 that of a major teaching center in New York. At the Frontier Nursing Service, since 1952, there have been no maternal deaths in 8,000 deliveries and in the 10,000 preceding births, that rate was 1/3 of the country.

> "The low maternal death rate is particularly significant since 60 per cent of deliveries between 1925 and 1954 were conducted in the home in an extremely poverty-stricken area, where the main mode of transportation was by horseback, modern facilities and medical assistance were difficult to attain, and the percentage of high-risk mothers and infants was great."

I hasten to add that the back-up hospital was as far as 40 miles from homes. An interesting sidelight is that the FNS, after 50 years of home birth, in 1975 opened a modern hospital. This information is often cited by opponents of out-of-hospital birth as evidence that home delivery is unsafe. It is my information that it was rather the unavailability of third-party reimbursement for home care that precipitated the hospital's construction. It is also interesting that after a year's operation the service reported both a drop in preventive visits in the home and escalating costs for hospital acute care visits. It is time this restrictive economic barrier to the provision of nurse-midwifery care be destroyed. I urge you to do so!

Mr. FLORIO. Unfortunately, before you go on I am going to have to go vote. I will be right back.

[Brief recess.]

Mr. FLORIO. Please proceed.

STATEMENT OF KITTY ERNST, C.N.M., M.P.H.

Mrs. ERNST. I would like to speak to three points.

First, I have a little trouble with the term "physician extender." I don't know how to "extend" a physician. I do know how to work with a physician to extend care. I don't know what the word should be, so I will leave it at that.

The Frontier Nursing Service is where I trained as a nurse-midwife 25 years ago. The service was established by Mary Breckenridge who, as you may know, was a person with a lot of vision and a great pioneering spirit. She set up a model for a decentralized program of care at a time when everything was moving toward centralization; at a time when we were trying to corral mothers into hospitals so that we could monitor their pregnancy, their labor and their delivery experiences.

The model demonstrated by the Frontier Nursing Service provided a centrally located medical care facility, with outpost centers staffed by public health nurse-midwives. For almost 50 years this model has been copied by people from all over the world. It could well have been one of our major exports in health care, because it met the health needs of pople in underdeveloped countries. A great strength of the model was the effective and efficient utilization of personnel. Every person in the Frontier Nursing Service at that time was asked to realize their greatest potential. The growth of the nurse-midwife was not stunted because the services rendered did not fit on a reimbursement form.

Two years ago I returned to the Frontier Nursing Service. I found some startling changes.

The service is now directed by a physician. There is a brand new hospital on the side of the mountain with a full complement of physicians and nursing staff. With the aid of Federal and private foundation moneys the educational programs for nurses have been expanded. Young people in the community are being trained as home health aids. Progress is evident—not only in visible growth of services, but in cost that becomes increasingly difficult to meet. A critical issue to be resolved if the present system is to survive, is the reimbursement for nurse-practitioner and nurse-midwife services. There is a great desire to retain the preventive aspects of care inherent in the decentralized model demonstrated to be so effective over the past 50 years—but the system for reimbursement appears to be a significant factor in forcing centralization—hospitalization. One wonders, for example if the shift from the home to the hospital for normal childbirth could have been indirectly caused by the fact that medical insurance, including medicaid, paid for hospital birth only. I will speak to a reversal of this trend on the part of some childbearing families in a moment.

The nurse-midwife, and now the family nurse-practitioner, working in consultation with the physician has been largely responsible for the success of rural health care in the Appalachian Mountain area served

by F.N.S. However, the effective utilization of nursing and medical manpower demonstrated there is at risk today—largely because the services rendered are not eligible for reimbursement unless the physician is present or unless the family member is admitted to the hospital.

Preventive care is the sine qua non of the nurse-midwife and the nurse-practitioner. The F.N.S. has demonstrated its effectiveness by reducing the need for costly hospitalization. This does not help occupancy rates in the new hospital but, perhaps in rural areas at least, we should give special consideration in reimbursing systems that keep bed occupancy down by emphasizing effective preventive and home based health care.

Finally, as the budget of the Frontier Nursing Service and other like, voluntary health care agencies multiplies, to meet the cost of expanded service and educational programs, the resources and reserves drain away. The voluntarism upon which the service was built, cannot continue to compensate for the lack of an on-going system of third-party reimbursement for the expanded services rendered.

It will be a great tragedy for the people and for all of us if this kind of health care institution becomes a victim of an unresponsive and inequitable payment system. Therefore, I support the payment of nurse-practitioners and nurse-midwives as you have proposed it.

The third point I would like to speak to is the ground swell of reaction among certain childbearing families who are seeking an alternative to the traditional hospital birth experience. We have a much more informed public today.

When I talk with childbearing families I find that they are reading the medical journals, and that they understand what they are reading. As a result of that understanding, and their own experiences, they have come to look at birth quite differently. They ask legitimate questions, which aren't always answered. Consequently, they have taken it upon themselves to begin to develop some of their own alternatives for care—like do-it-yourself home birth.

I am currently working with several groups in the eastern Pennsylvania area, who are exploring the feasibility of birth centers as one alternative. These are responsible people—who feel that we must find a better way to start families.

Mrs. LUBIC. And one is in New Jersey.

Mrs. ERNST. In working with these groups, it becomes apparent that there will be a real problem in development and survival if third-party reimbursement is not available to nurse-midwives working in consultation with the obstetrician/gynecologist. It has been suggested more than once, that nurse-midwives developing alternative birth services should set up private practice and collect fee for service. I have to say that my philosophical view is that health care should not be for unlimited profit. Therefore, I do not see nurse-midwives replicating the medical model of fee for service. If we are to make quality care available to all of the American people, we must ever explore new systems for delivery of that care at a cost that we as a society can afford.

Lastly, I feel that nurse-midwifery should be mentioned in the bill for the same reasons that Mrs. Lubic has already mentioned.

Thank you.

Mrs. LUBIC. I just wanted to add one thing, Representative Florio, about the idea of backup. This backup has been something of a problem for us, although we have had backup services available from the beginning of our demonstration. It is one of the things that has made life a little more difficult in terms of professional opposition to what we are doing. I would be enchanted if there were in the bill a specification that acute care settings have a responsibility to provide backup to primary care settings, not only for maternity services, but I think it is particularly poignant in maternity. Even though in our unit we screen the families very carefully, emergencies can occur, and we still need to have backup facilities in order to transfer families when they are unable to complete their pregnancy and labor in our setting. So that would be a very important thing to us. I have seen the lack of adequate backup used against the viability of units like ours.

Thank you.

Mr. FLORIO. I would just like to thank you both for very interesting and informative statements. As you probably know, I have legislation that, quite candidly, I am going to try to introduce via the amendment process into this bill so that the whole question of midwife facilities will be adequately addressed in this bill as it is ultimately passed in this committee, hopefully. So I thank you both for your cooperation.

Mrs. LUBIC. Thank you.

Mr. FLORIO. Our last panel consists of Mr. James Bernstein, as well as Miss Nancy M. Lane.

Mr. Preyer asked me to give you his regards.

Mr. BERNSTEIN. Oh, thank you.

Mr. FLORIO. Whoever desires to may proceed first.

STATEMENTS OF JAMES D. BERNSTEIN, CHIEF, OFFICE OF RURAL HEALTH SERVICES, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, ALSO ON BEHALF OF THE NATIONAL GOVERNORS' CONFERENCE; AND NANCY M. LANE, HEALTH PROGRAM ANALYST, APPALACHIAN REGIONAL COMMISSION

Mr. BERNSTEIN. Mr. Chairman and members of the committee, my name is James Bernstein and I am representing the National Governors' Conference and the State of North Carolina which, as one of the Nation's most rural States, has moved aggressively in recent years to provide its rural residents with access to quality primary medical care.

As a member of the staff of the department of human resources, it has been my privilege to serve as the chief of our office of rural health services, created and funded by North Carolina as an innovative effort to assure access to care to some 55 percent of our population residing in communities of less than 2,500 persons.

Though our office is heavily involved in assisting physicians find appropriate practice sites in our rural areas, we have also developed 17 outstanding primary care centers in physicianless communities which are staffed by physician extenders, family nurse practitioners, and physician's assistants, who deliver care under the remote supervision of physicians in neighboring commercial centers.

These clinics provide access to care to some 51,000 rural residents and, though some are in early stages of operation, are providing services at the rate of 60,000 medical encounters annually.

The extender clinics have been well received by the communities. Patient rosters demonstrate this reception by their containing a good cross section of the local population. Excellent payment rates portend well for the future of the clinics.

Our efforts in these rural areas are based upon our understanding that the character and quality of rural residents are rural North Carolinians' greatest resource. Our conviction has been that given adequate technical assistance to acquaint rural leaders with the elements of medical delivery systems, such leaders become the best guarantee of access to quality medical care services.

Over the past 4 years the system has been carefully observed by the medical community at all levels. Support for the clinic concept in our State has grown from an outstanding group of leaders in the early 1970's. Today the concept is generally endorsed throughout the medical community.

Our units receiving State assistance were planned to achieve self-sufficiency from patient revenues in an average of 3 years. We are pleased with their progress.

A persistent problem, however, has been the refusal of medicare to reimburse these clinics for services rendered those insured by their program because the supervising physician is not always present in the facility.

Medicaid reimbursement presented a similar hurdle when our system was initiated but, due to greater State flexibility, was quickly and effectively resolved.

Our staff, working with that of the medicaid program, sought a method of reimbursement which would be fair to medicaid and clinic alike. The principle at issue was that medicaid bear only its fair portion of the costs rather than a portion which, in fact, would amount to a subsidy of the operation. The result was a contract for cost-based reimbursement to the clinics calculated at a level of patient flow which would produce self-sufficiency rather than actual cost while in a start-up mode. The agreed reimbursement per encounter was $12, whether the service was a brief return visit or a complete physical exam including extensive lab work and an EKG. Contracts did make provision for adjustments on the basis of audit, but the $12 has proved an excellent projection and no adjustments have been sought thus far.

The best way to illustrate costs to the medicaid program is by reviewing the operation of five of our more developed units in fiscal year 1976. For these five units, cost to medicaid at the $12 rate totaled $36,673 for 3,056 service encounters. This amount represented 11 percent of the income of those centers during the year and was generated by 12 percent of the patient encounters.

Projecting this experience over our 18 centers at full operation we would project some 12,960 medical encounters generating a cost to medicaid of $155,520 for a year's service. Naturally that is the total medicaid bill, and the State would pick up its proportion, which is somewhere around 20 percent.

I do not have data to indicate whether this represents a reduction or increase in cost to the medicaid program. Medicaid recipients served by our programs might seek care in private physicians' offices, in hospital emergency rooms, or not at all. Care in emergency rooms for the same encounters would be twice the clinic cost, and this resource, even though inappropriate, is more likely chosen in the areas we serve. I cannot estimate the impact of the primary care clinics on hospitalization but a federally funded study by the Mitre Corp. in one of our clinic areas would tend to indicate some decrease in hospital usage which may be attributed to the presence of the physician extender clinic.

North Carolina obviously believes that primary medical care provided by physician extenders should be reimbursed by medicaid because it is quality medical care under the laws of our State. We have found our cost reimbursement based upon cost of a fully operational, financially viable system is acceptable to us. We would encourage other States to consider similar action.

After reviewing House bill 8543 briefly, I have some concern about three parts of the bill. First, I believe the section of the bill defining rural areas eligible for reimbursement puts too much emphasis in law on the definition for medically underserved populations under section 1307(7) of the Public Health Service Act. The formula used is not as sensitive as it should be and will eliminate from reimbursement some clinics in North Carolina and the rest of the country that have been delivering needed services for several years.

I would strongly recommend that the wording be changed back to that in House bill 2504 which provides greater flexibility for the Secretary in the area of designation. In addition we believe a grandfather clause covering these clinics presently in operation should be added to the bill. Realizing that medically underserved area designation changes over time, we assume that once designated eligible for reimbursement a clinic will continue to receive reimbursement regardless of a change in area designation status. Otherwise the incentive to improve health services for a community is lost.

Second, I am concerned about the process of determining the reimbursement rate. Most rural health clinics have extremely small staffs, many consisting of two or three people. If we want to keep these practices efficient, we cannot expect them to maintain sophisticated cost-accounting procedures which would differentiate between the average cost of a medicaid recipient, a medicare beneficiary, or a private pay patient. We have found that quality primary care for the poor and the elderly usually involved more time and expense than the rest of the population. Therefore, an across-the-board 80 percent of cost reimbursement rate would unfairly penalize the majority of the patients who use the clinic who are not covered by medicare or medicaid.

Given the size of these operations, a small loss in revenue can make the difference between success or failure of the entire operation. Rather than putting the burden on the clinics to maintain a sophisticated cost accounting system, I suggest weighted system wide multipliers be used for medicare and medicaid patients based on the results of a comparative study carried out by the Secretary. For example, if it is determined that the average medicare beneficiary visit costs 10 percent more

than the average visit in the study, medicare would reimburse 80 percent of the 110 percent of the average encounter cost for all clinics covered by this law. The same concept could be used for medicaid patients. This system would be simple to administer and reduce any financial barriers for the poor and elderly.

The third area of concern is the requirement that reimbursement for medicaid services by physician extenders be made mandatory where legal. The National Governors Conference recognizes the need for physician extender services, especially in our rural areas, and supports and encourages its membership to make use of the concept to make primary care more accessible.

The conference is more concerned that States have ample flexibility in terms of time and mechanism to establish viable medicaid programs meeting their budgetary and legal constraints.

In addition, we feel there is a good possibility that mandatory reimbursement could discourage States from expanding their nurse, pharmacy, and medical practices acts permitting physician extenders to operate in rural clinics.

For these reasons, the National Governors Conference recommends that this provision be optional rather than mandatory. With the exception of these concerns the National Governors Conference and the State of North Carolina strongly support the committee's efforts to make available an accessible primary health care services to our poor and elderly.

Thank you for inviting me to testify today.

STATEMENT OF NANCY M. LANE

Ms. LANE. I, too, would like to thank you, Mr. Florio, for your endurance during these hearings, as well as taking time to endure them for us.

My name is Nancy M. Lane. I am a health program analyst on the staff of the Appalachian Regional Commission. For the past 5 years I have been part of the commission's program to place primary care clinics in communities where access to health care is an identified problem.

The Appalachian Regional Commission programs are developed and administered in partnership between the administration and the Governors of the 13 Appalachian States. We have two cochairmen. One is former Governor Robert W. Scott, who was just appointed by President Carter, and Governor Marvin Mandel of Maryland, who was selected by the Governors as States' cochairman. The member States pay half the costs for administering the commission and have an equal role with the administration in determining the commission's goals and priorities.

The population of the 13-State region is largely nonmetropolitan; 45 percent of the 19 million people live in open country or towns of less than 1,000 persons. Another 8 percent live in slightly larger, but still nonmetropolitan areas. Consequently, we tend to be concerned about issues that affect rural people.

I have a prepared statement that I would like to have submitted for the record and in our own interests, and in the interests of the time of the folks here, begin to synopsize.

Appalachia's concern is by now no secret to Members of the Congress and people around the country. By October 1, we will have funded 240 primary care projects funded under the authority of the Appalachian Act. This authority gives us permission to support the deficit of a program for as many as 60 months. Beyond 60 months we have no authority.

Since we have been now more than 5 years into the clinic program, we have many that have reached the end of their statutory limit for support.

We are not Johnny-come-lately's to worrying about the financial survival of our clinics. Four years ago we recognized that the clinics would not be able to survive unless we did something about third-party reimbursement.

At the time medicaid, medicare and private insurance were all concerns. You asked earlier about medicaid and medicare volume in the clinics. I have done a "quick and dirty" survey of the distribution of patients in the clinics. More than half are self-pay. If the other half depend on third parties that don't reimburse, you have a problem.

In 28 States medicaid programs now reimburse for nurse practitioner and physician assistant services. Private insurance, particularly Blue Cross, has tended to follow the pattern set by the medicaid program. In medicare change requires change in Federal law. Medicare use of the clinics represents anywhere from 10 to 30 percent of the volume, depending on the population of the area.

I would like to express our appreciation to Congressman Carter and Congressman Broyhill who are not here, but who have been long, long supporters of an attempt to make this type of a change in the medicare law.

Before going further, I would like to take a few minutes to point out why the Commission started funding clinics. We have broad authority to fund comprehensive health services and show their significance in economic development. ARC started out with the traditional methods of health care, hospitals, ambulances; we tried also helicopters and fixed-wing vehicles. We supported some home health services.

In the early 1970's we discovered that Frontier Nursing Services, which had started long before us really did have a better idea, and we tried their nurse practitioner clinic model.

Since that time the concept of clinics has spread from early acceptance in Kentucky, Tennessee, and New York to today when all 13 States are making heavy investments in primary care.

Clinics continue to provide low-cost services. Their quality stands up under review of the most Doubting Thomas of physicians. Scholarly literature today is full of quality studies. A few do stand out. One to be noted is the Burlington studies of nurse practitioners, not in Appalachia, but in Canada where they are part of the national health insurance system. In a randomized trial conducted over a period of 3 years, they found out the quality differences between the nurse practitioner and physician care were negligible.

Another very important part of our commitment to nurse practitioners and physician assistants is the fact that we can continue to get them into Appalachia. Despite a number of recruiting programs for Appalachia, there are still many communities to which we cannot at-

tract physicians. However, when we establish an organized primary care center we are able to recruit the nurse practitioner and physician assistant, and in many instances that center with the established practitioner then draws a physician.

The definition of a clinic is always a very difficult question to answer. It varies with the size of the population to be served. From the table of budgets of 19 rural clinics and one urban, you find somewhat of a pattern.

The average clinic serves 2,800 people. Eighty percent of the clinics are in towns of fewer than 10,000 people. The annual medical care cost in the clinics per person served is about $55. This compares favorably to the national bill of $121 per person for outpatient services in 1976.

The Commission has over a period of time developed a series of criteria to describe our primary care clinics. In addition to the laboratory, pharmacy and hospital referral that you have required in your bill, H.R. 8543, we also find that standing orders that are a product of the negotiation between the supervising physician and the extenders are essential; a supervising physician is legally responsible for the quality of care and accessible for referral; that problem-oriented medical records are kept on all patients; that services be geographic or population-specific; that we have internal quality controls such as a regular record audit; that regular in-service programs are held for physician extenders and supervising physicians; telephone consultation and home visits are available; that emphasis is placed on patient education and counseling; and that there is follow-up on missed appointments.

These are all very difficult to measure, but when you take a look at the successful clinics these are the qualities that stand out.

As far as cost is concerned, we have found that $60,000 will set up a clinic for two nurse practitioners, against $80,000 to set up a clinic for one physician. This cost continues to sell the region on the merits of very small clinics.

I would like to make a few comments on the bill that you have under consideration. The addition of medicaid as a mandatory service is acceptable to the Commission. This is something that the Governors have seriously considered, and as a majority accepted.

The addition of prevention and nursing home visits when those services are included in the State medicaid plan is also a very welcome addition.

The fact that you accept those clinics that have full-time as well as part-time physicians is again welcome to the Commission. Our clinics are evenly divided between the two models.

We have some concerns about applying the medicare reasonable cost methodology to the definition of cost in these clinics. When this has been applied to home health services, the costs have escalated far beyond the cost for care in our clinics. The States have been able to keep the cost, the average total cost per visit, down to around $18. This is because they have been very careful about the addition of unnecessary equipment and personnel. If you don't design a cost formula that gives the Secretary or someone the opportunity to challenge costs, I fear that we will not be able to boast these low costs in a few years.

We share the concerns of professional associations with the term "physician extender" and support the change to "nurse practitioner and physician assistant," which seems to comprehensively describe the professionals concerned. The nurse-midwives may take issue with us. We have subsumed nurse midwife under nurse practitioner, but the Commission is a wholehearted supporter of the nurse-midwife.

It has been a concern of the States that certification and licensure are in their domain, and they would prefer to see the definition of nurse practitioner or physician assistant left with the State rather than the Secretary.

Your bill has in it a provision for certification of the primary care clinic that permits the Secretary to interpret health and safety standards. Again concerned about our past experience, we would hope that if you find these standards necessary, you would apply the simple types of standards that are applied to a physician's office, adding perhaps the criteria for care for handicapped provisions and criteria for location in flood zones. We would not welcome application of hospital outpatient department standards to these primary care centers. Experience in Tennessee showed us that this eliminated the small clinic housed in a double-wide trailer. For example, you don't need a 3-hour firewall if everyone can exit the clinic in 5 minutes. I choose that only as an example of my concern.

We would welcome uniform reporting. This would make accounting in clinics much more simplified. We support Mr. Bernstein and Mrs. Davis on the definition of medically underserved areas. Grandfathering clinics to preserve reimbursement once they become certified should their area lose designation as medically underserved; to have them thus lose their reimbursement would be to destroy everything that you have done in passing the bill.

At this point I would like to stop and thank you again for the opportunity to testify and answer any questions you would like to ask.

[Testimony resumes on p. 120.]

[Ms. Lane's prepared statement and attachments follow:]

STATEMENT OF

NANCY M. LANE, HEALTH PROGRAM ANALYST,
APPALACHIAN REGIONAL COMMISSION,

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES SUBCOMMITTEE ON HEALTH
AND ENVIRONMENT OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

July 29, 1977

Mr. Chairman:

My name is Nancy M. Lane; I am a health program analyst on the staff of the Appalachian Regional Commission. For the past five years, I have been part of the Commission's program to place primary care clinics in communities where access to health care is an identified problem. Appalachian Regional Commission programs are developed and administered in partnership between the Administration and the Governors of the thirteen Appalachian States. We have two Cochairmen, former Governor Robert W. Scott, who was just appointed by President Carter and Governor Marvin Mandel of Maryland, who was selected by the Governors as States' Cochairman. The member states pay half of the costs for administering the Commission and have an equal role with the Administration in determining program goals and priorities.

The population of the 13-state region is largely non-metropolitan; 45 percent of the 19 million people live in open country or towns of less than 1,000 persons. Another 8 percent live in slightly larger, but still non-metropolitan areas. Consequently, we tend to be concerned about issues that affect rural people.

ARC Role

Since 1965, the Commission has tried to develop programs that would improve rural health status without draining rural purses. We have also tried to focus on health rather than medical care. Primary health care clinics staffed by new health practitioners, nurse practitioners and physician assistants specially trained in diagnosis and treatment of common health problems, are one of our successful solutions. More than 80 percent of the 200 clinics funded to date are located in towns of 10,000 or fewer people. An average clinic serves 2,800 people, though a few serve more than 10,000. The average annual medical care cost per person served in one of these clinics is $55.

ARC has legislative authority to provide communities with deficit funding for both construction and operating costs, but authority for operating costs is limited to 60 months. Four years ago, we recognized that these clinics would not meet the second legislated mandate -- financial self-sufficiency -- unless something was done to change reimbursement policies. Medicare, Medicaid and the insurance companies, in most cases, did not cover the services of the new health practitioners. The UMW Health and Retirement Funds were an exception. The clinics organized task forces to deal with each third party. The Commission supported them. As the number of clinics and practitioners increased, the States have changed their Medicaid programs. Today, 28 Medicaid programs reimburse practitioner services; 9 in Appalachia.[1,2/] In most cases, when Medicaid changed, Blue Shield followed. Medicare, which represents as much as 30 percent of the usage, remains unchanged. Since clinic budgets are tight, their survival requires cooperation by all payors.

Concerned about the plight of the clinics, the Commission, at a meeting in Annapolis, Maryland, March 21 of this year, adopted a resolution calling upon President Carter to join us in a request to Congress to act quickly on legislation to permit Medicare reimbursement for these services. Specifically, that resolution states:

WHEREAS, the overall Commission program of developing primary health care services in underserved rural areas is seriously jeopardized by the failure of Medicare to reimburse physician extenders, and

WHEREAS, even though the total question of reimbursement is complex and affects other professions, the settlement of the question of reimbursement for physician extenders should not be postponed until all the complex issues on all related matters have been totally resolved, and

WHEREAS, the Carter Administration has endorsed legislation now pending before the Congress, which, when approved, will overcome existing limitations under Title XVIII of the Social Security Act, and

WHEREAS, the people served by these clinics have no alternative accessible sources of health care;

NOW, THEREFORE, BE IT RESOLVED THAT:

The Appalachian Regional Commission hereby expresses its appreciation to President Carter for his support of pending legislation, and

Hereby requests priority attention to the Administration's efforts and prompt passage of appropriate Legislation.

June 1976, the Commission passed another resolution that outlines the conditions under which the members endorse reimbursement for physician extenders. Specifically, these are:

(a) The physician extender is functioning in an organized health care system;

(b) The physician extender is providing medical services according to written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present;

(c) The physician participating in the written orders assumes full legal and ethical responsibility as to the necessity, propriety and quality thereof;

(d) The reimbursement be provided at a rate commensurate with the services provided, rather than the provider of services; and

(e) The reimbursement be made to the clinic or sponsoring organization.

Last month, the Governors, recognizing the need to start where the problem is acute and to open the issue gradually, accepted the language of the attached Rural Coalition resolution.

ARC Clinic Problems

With the number of ARC-supported clinic projects expected to reach 240 by October 1, the problem is even more acute for the Appalachian people.

Forty clinics will reach their 60-month limit this year. Twelve have been able, with the cooperation of the Secretary of DHEW, to obtain another temporary lease on life through the RHI grant program. A few have closed; nine have pending requests; ten more are uncertain. In Central Appalachia, where many clinics became self-sufficient, the problem is just becoming clear. The United Mine Workers Health and Retirement Funds formerly paid 100 percent of charges, fully intending to cover a share of indigent care costs, but they have cut back. The funds have been seriously troubled by strikes, floods, freezes and other events that reduced coal tonnage this year.

Once grants end, the clinics must either find their support from non-federal sources or restrict services to people who can pay total costs. Unfortunately, many eligible people are thus required to pay twice because the service cannot be reimbursed under Title XVIII, Part B of the Social Security Act, to which they have subscribed. Currently, Title XVIII prohibits reimbursement for services of the new health practitioners, unless a physician is present and immediately reviews the diagnosis and treatment provided.

If these clinics fail, we will have destroyed the growth of an alternative to expensive hospitalization. At their current rate, ARC clinics provide chronic care visits to Medicare patients at one-sixth (1/6) the price of a single day in the average hospital.[6/] A study recently completed for the ARC by the Mitre Corporation[7/] suggests that these clinics contribute to reduced hospitalization -- 10 to 30 percent over paired control communities.

Table I samples clinic use by payor. Self-pay is the largest category, but the clinics cannot survive with 22 to 36 percent of their volume unreimbursed.

National Problem

The problem is not confined to Appalachia. Since we first raised the issue, we have received letters from clinics across the country. The Old West and Southern Governors have joined ours asking for change. The difference of urban and rural per capita reimbursement under Part B Medicare is 61 percent. Although the span is a product of many factors, a closer look at West Virginia, on a county-by-county basis showed the counties with the lowest rates were also the counties without physicians.[3/]

The recent health manpower legislation notwithstanding, physicians are not moving to Appalachia. In some rural parts of Appalachia, particularly the rural South, physicians are still leaving.[8/] Yet, with grant support, practitioners have been willing to settle in the same towns vacated by physicians.

If the new health practitioners could not be attracted to the remote settings like Clairfield, Elkland, St. Charles, Farmington, Briceville and Washburn, the Commission program would not have grown so. Their turnover is still high; the average stay is 2.5 years; but they come. A recent study by the University of North Carolina Department of Economics showed that the financial stability provided by the grants is a major factor.[5/] Their study included 101 rural clinics.

We do not know the exact number of rural clinics. However, the estimated 700 cover about 20 percent of the rural medically underserved areas.

Clinic Structure

ARC has always stressed organized clinics. Personnel can turn over, but a well-organized clinic can absorb the change. The North Carolina study referenced earlier shows that the longer a clinic is in place, the less its stability is affected by a change in personnel. This is in sharp contrast to the trauma caused by the departure of solo or partnership physicians from small towns.

Clearly, a bill to permit reimbursement to clinics is in the best interest of the small towns and rural areas of this country. The type of organization -- profit or non-profit -- is not as important as the internal components. By experience, we have found that successful clinics share common features; besides access to x-ray, laboratory, pharmacy and hospitals.

-- written standing orders (protocols) that are a product of negotiation between supervising physician and extender(s).

-- supervising physician legally responsible for quality of care.

-- problem-oriented medical records Rept on all regular patients.

-- geographic or population-specific services.

-- internal quality controls, such as regular record audit.

-- provision for regular inservice conferences between physician extenders and supervising physicians.
-- appointment systems that make professional care and advice easier for patients to obtain.
-- available telephone consultation and home visits.
-- emphasis on patient education and counseling.
-- follow-up on missed appointments.

Quality

Every new profession must make its case for quality, if it is to be accepted by the consuming public. Studies of quality of the nurse practitioner and physician assistant are almost legion. All are positive. Though most are done on small samples with narrow definitions of quality, a few stand out. For five yeras, Runyan of Tennessee[13] has followed 1,006 patients treated by nurse practitioners in satellite ambulatory care centers. Those patients continue to have lower blood pressure, lower blood sugar and 50 percent lower hospitalization rates than paired cohorts in hospital outpatient departments. In a few studies, surgery rates have increased, suggesting that np's and pa's should not be exempted from quality and utilization controls.

In Ontario, where nurse practitioners are part of the National Health Insurance program, Sackett and his colleagues did a one-year randomized comparison of practitioners and physician care for 1,598 families. By their measures of quality, the outcome of care in the two groups was identical.[14]

The criteria for a successful clinic are also criteria for quality. Congressman Rogers and Dr. Carter, you have built a system of certifications into your bill that should both prevent abuse and permit the types of activities that improve quality.

Residents of medically underserved areas see doctors as frequently as residents of served areas -- for acute care. In rural areas, because of the travel problems, the medically underserved short-change themselves for preventive services and health maintenance.[4/] It is in the shift to health maintenance that we see the reduced hospitalization that has been documented in the studies by Davis,[10/] Runyan,[11/] Isaacs[12/] and Anderson.[13/]

Critique of H.R. 8543

(1) We endorse reimbursement for services of physician extenders when they are provided in clinics staffed by full-time as well as part-time physicians. Appalachian clinics are about evenly divided between the two types.

(2) The bill's concept of making coverage for rural clinics mandatory under both Medicare and Medicaid is acceptable to the Commission, with but one reservation. In States where a simplified cost-reimbursement program is already in effect, this law should not make it more cumbersome.

(3) Reimbursement based on costs is good. The Medicare definition of "reasonable costs" has in the past led to uncontrolled escalation of costs, particularly in the home health program. ARC clinics presently operate on moderate standards that keep their costs low. The all-inclusive cost per visit now averages $18. Medicaid programs in North Carolina and Tennessee have managed to control costs near that average. It is difficult to judge from the language of the bill whether or not you have continued to permit the States and the Secretary to exercise discretion with regard to the costs. I hope that is your intent.

(4) In referring to the new health practitioners, H.R. 8543 uses the term, physician extenders. The Commission appreciates the concerns of the professionals who have been broadly grouped under this term in previous years, and endorses changing the term to the more specific terms, "nurse practitioner" and "certified physician assistant."

(5) The definition of physician extender in H.R. 8543 is left to the Secretary. It is the Commission's position that certification be left in its traditional place, with the States. This permits States to accept current professional exams, and we would endorse a recommendation to do so, but it also encourages the States to experiment and develop new and better vehicles.

(6) Unlike the House bills, S. 708 defines a cooperative relationship between physicians and the new health practitioners (Section (C) of (aa)(2) amending Section 1861). We have found that when physicians and new health practitioners jointly prepare the protocols (or standing orders) for medical care, they develop a better sense of agreement and of each other's skill and background levels. The patient benefits.

(7) H.R. 8543 authorizes such other requirements as the Secretary may find necessary for the health and safety of clinic patients. It also requires certification by the State agency that clinics meet the requirements of the bill and other regulations prescribed by the Secretary. Taken at face value, these seem like reasonable requirements. Past experience shows that broad discretionary authority to regulate by the Federal Government can lead to defining standards that may add to costs. Minimum standards, such as those applied to physicians' offices, not the standards for hospital outpatient departments, should be the certification standards for rural heatlh clinics.

(8) Finally, uniform reporting procedures for Medicaid and Medicare would keep both auditing costs and clinic administrative costs reasonably low under the requirements of this bill.

FOOTNOTES

1. Kalmans, Pat, "Initial Survey Findings: State Reimbursement for Reimbursement for Clinic Services," Georgetown University Health Policy Center, June 27, 1977.

2. Ridley, Don, "Table of Medicaid Reimbursement for Physician Extender Services," staff paper, April 1977.

3. Aston, Lydia, "What's Happening to West Virginia's Medicare Dollars?" West Virginia Journal of Medicine. February 1976

4. Joel C. Kleinman and Ronald W. Wilson, "Validation of the Medically Underserved Area Designation," presented in part at 104th American Public Health Association meeting, National Center for Health Statistics/HRA/DHEW, April 1977.

5. David M. Deitz, Roger Feldman and Edward F. Brooks, "The Economic Viability of Rural Primary Health Care Centers," research paper from NCHSR/HRA/DHEW grant number HS 01971, Chapel Hill, N.C., May 1977.

6. SSA/OPPP/ORS Health Insurance Statistics Bulletin No. HI-76, March 4, 1977, DHEW, Washington, D.C.

7. Carol Anderson, Ed Nedham, Donald Vicary, "Effect of Primary Health Care Provided by Physician Extenders on Total Community Health Costs," February 1977 (ARC, Contract No. TQ-41).

8. Jerome Pickard, ARC data file, January 1977.

9. Unpublished SSA/DHEW actuarial estimate, February 1977.

10. Karen Davis, "Health and the War on Poverty," P 5-39, The Brookings Institution, Washington, D.C. (draft to be published).

11. Runyan, John, M.D., "Ambulatory Health Care Approaches to Chronic Illness," paper presented at Naval Regional Medical Center, San Diego, February 12, 1976.

12. Karen Gordon and Gertrude Isaacs, "Reduced Hospitalization Through Decentralized Care of Chronically Ill," Frontier Nursing Service, Hyden, Kentucky, December 1975 (unpublished).

13. John W. Runyan, Jr., M.D., "The Memphis Chronic Disease Program Comparison in Outcome and the Nurses Extended Roles", JAMA 231(3): 264-267, January 20, 1975.

14. Sackett, DL; Spitzer, WO; et. al., The Burlington Ramdomized Trial of the Nurse Practitioner, Health Outcomes of Patients, Annals of Internal Medicine, 90:2 (137-142) February 1974.

June 14, 1977

MEMBERS OF THE SENATE FINANCE AND HOUSE WAYS AND MEANS COMMITTEES:

The organizations listed below endorse the following principles as the basis of legislation to bring health services to medically underserved areas--

1. The most urgent, critical need for health services exists in medically underserved small towns and rural areas, many of which rely upon primary health clinics staffed by nurse practitioners or physician assistants. Therefore, Medicare reimbursement should be expanded to cover health services provided by those clinics, as a first step toward reimbursement by all third-party payers, for primary health services in all medically underserved areas.

2. Reimbursement for clinic services should be related to the cost of providing the primary health services, should go to the clinic rather than to any particular provider, and should cover physician services in addition to those provided by nurse practitioners and physician assistants.

3. Public primary health clinics and primary health clinics that receive Federal operating funds that are located in urbanized medically underserved areas should be eligible for cost reimbursement on a demonstration basis.

4. In recognition of the fact that physicians in private practice that employ nurse practitioners and/or physician assistants help fill the gap of primary health services in small towns and rural areas, and since many such physicians are reluctant to become salaried providers within a clinic, they should be allowed another option. On a one-year demonstration basis, they should be permitted to choose fee-for-service reimbursement covering the services of the nurse practitioners and physician assistants they employ, at a rate that is equivalent to the physician's usual and customary rate. Physicians that select this option should not be permitted to employ more than two physician assistants or nurse practitioners.

5. The Secretary of Health, Education, and Welfare should report to Congress one year after implementation of this legislation on the rural and urban demonstrations and on the rural cost reimbursement arrangement. This report should address the questions of expanding the program to urban areas and continuing the fee-for-service arrangement.

6. Except for the urban demonstration component, a clinic or practice eligible for reimbursement should be one that serves a rural, medically underserved population. "Rural" should be defined as an area that is not "urbanized", a Bureau of the Census term that would, in effect, exclude communities over 50,000 and their suburbs. Clinics or practices receiving reimbursement in areas that lose their designations as "medically underserved" should continue to receive reimbursement.

We urge the House Ways and Means Committee and the Senate Finance Committee to promptly act upon these principles, so that primary health services will be more accessible to medically underserved Americans.

American Academy of Physician Assistants

American Nurses' Association

American Hospital Association

Appalachian Regional Commission

Association of Physician Assistant Programs

Friends Committee on National Legislation

National Association of Community Health Centers

National Association of Counties

National Association of Farmworker Organizations

National Association of Social Workers

National Council on the Aging

National Council of Senior Citizens

National Farmers Union

National Retired Teachers Association/American Association of Retired Persons

National Rural Center

National Rural Electric Cooperatives Association

United Mine Workers of America Health and Retirement Funds

THE APPALACHIAN REGIONAL COMMISSION
1666 CONNECTICUT AVENUE
WASHINGTON, D.C. 20235

Date: July 27, 1977

Subject: Primary Care Practitioner Survey

To: Nancy Lane

Pursuant to the hearings being held on the revision of Medicare legislation, I thought the following information might be useful. These data originated from the Project Information System reports from 1975 and 1976. They were taken from all available reports from primary care programs; however, you will note that the return rate of approximately 29 percent is much lower than for other ARC-funded health programs (75 percent).

1. Number of centers surveyed: 57 = 29%

2. Number of centers, employing one or more of the following: Nurse Practitioners, Nurse Clinicians, Physicians Assistants and Physician Extenders: 43 = 75%

3. Number of primary care practitioners: 68 (survey)

4. Number of ARC-funded primary care clinics with primary care practitioners: 150 clinics (estimate)

5. Number of PP/clinic: 1.6 (average)

6. Total number of ARC-funded primary care practitioners: 240 (est.)

Geographic Dispersement (# of NPs, PEs, PAs, NCs and % of Total Number)

1. Urban (at lease one town with a population over 10,000): 13 = 19%

2. Small Urban (at least one town with a pop. between 2,500 and 9,999): 4 = 6%

3. Small Town (at least one town with a pop. between 1,000 and 2,499): 35 = 51%

4. Dispersed Rural (no towns greater than 1,000): 16 = 24%

VIRGINIA GEMMELL
Health Evaluation Specialist

cc: Jim Kennelly

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TABLE I - DISTRIBUTION OF CLINIC VISITS BY PAYOR

PAYOR	% BY CLINIC						
	1	2	3	4	5	6	7
Self	28	55	66	63	34	49	40
Medicaid	10	6	18	15	29	19	23
Medicare	17	30	7	7	9	9	20
Private Insurance	4	9	9	15	10	23	17
UMW Funds	41	-	-	-	18	-	-

1. St. Charles Community Health Clinic, St. Charles, VA
2. Mitre Study, ARC Clinics, 1976
3. Neighborhood Health Centers - Rural, March 1976
4. Nurse Practitioner Clinics, Rural New Mexico, 1974
5. Laurel Fork - Clear Fork, 1976
6. Hot Springs, North Carolina, 1975
7. Grand Isle, VT, 1976

TABLE II

APPALACHIAN REGION
PRIMARY CARE CENTERS

FY 1976 BUDGETS

Project	Gross Budget	Equipment & Construction (-)	Net Budget	Dental Services (-)	M.D. Budget	Administrator Budget	P.E. Budget	Other Personnel Budget	Expense Budget	Cost/Person Served	PE/Net Budget	PE/M.D. Budget	PE/Other Per. Budget	Number Served
AL-4022	$ 142,211	$ 7,420	$ 134,791		$ 7,666	$ 38,362	$ 29,650	$ 38,509	$ 20,416	54	22%	386%	77%	2,500
GA-3904	73,243	17,500	55,743		6,832		15,590	13,641	19,679	51	28	228	114	1,110
KY-4341	398,142	37,550	360,592	$ 28,465	97,500	55,399	6,720	64,094	108,414	60	2	7	10	5,500
MS-2586	133,071		133,071		40,676	9,848	14,356	14,563	53,625	98	11	35	99	1,357
MD-382-07	115,747		115,747		23,278	26,745	7,952	25,763	32,007	38	7	34	31	3,021
NY-4592	447,930	34,000	413,930		160,886	14,400	15,409	82,560	140,674		4	10	19	1
NY-3420	76,664		76,664		48,000		1,491	10,970	16,202	48	2	3	14	1,600
NY-3421* 1/	220,333	7,643	212,690		128,625		17,910	38,555	27,600	11	8	14	46	20,000
NC-451-38	131,826		131,826			1,938	28,511	19,671	81,700	23	22		145	5,720
OH-3650	131,223	7,500	123,723		50,753	9,615	12,640	12,861	37,850	95	10	25	98	1,300
OH-3554	168,573	10,634	157,939				2,359	33,344	122,256	47	1		7	3,350
PA-4697	258,667		258,667	51,850	103,500		11,757	43,930	47,600	207	6		27	1,000
TN-3439	224,631		224,631		26,608	15,000	44,746	54,861	83,416	50	20	168	82	4,474
TN-4725	51,600	4,800	46,800		4,000	3,704	10,000	11,184	17,910	14	21	250	90	5,450
WV-4595	274,505	58,164	216,341	29,413	22,215		12,000	49,500	103,215	43	6	54	24	4,357
WV-4350	132,989	19,878	113,111		22,036	13,800	13,800	22,425	41,050	31	12	63	62	3,680
WV-4344	226,363	43,341	183,022		44,624	9,000	9,000	42,665	86,733	86	5	20	21	2,124
KY-3551	118,294	17,137	101,157	66,136	787	5,359	5,359	20,607	6,100	35	14	70	26	1,012
TOTAL	$3,105,679	$257,924	$2,847,755	$175,864	$659,359	$190,979	$241,370	$561,148	$1,018,827	36,992 ÷ $72	9%	37%	43%	45,555
AVERAGE	$ 182,687	$ 23,447	$ 167,515	$ 9,770	$ 43,957	$ 15,914	$ 14,198	$ 33,008	$ 59,931					2,867

Average Budget Less Construction and Dental = $157,745

At 20% Use By Medicare Patients
Annual Medicare Additional Cost = $ 31,549

= $55.40 per person served per year

* Urban Setting ≥ 50,000

1/ Not Included in Calculations

Mr. FLORIO. Thank you very much.

I think you both. I really have just one or two questions.

What is the experience with payments from Blue Cross-Blue Shield, particularly with the part-time physician? Is the physician required to signoff, or are there other personnel who are required to sign for services rendered or allowed to sign for services rendered?

Mr. BERNSTEIN. I am sure it varies completely from plan to plan, but in North Carolina there is an agreement such that the extender signs off. But it is done in such a way that the practice is certified, before they will reimburse a practice they want to know that the extenders have gone through the board of medical experts or the board of nursing, whatever has been done, and has to be done and proper, then they let the nurse practitioner or physician assistant sign the claim.

Mr. FLORIO. I see.

Ms. LANE. And I can speak more comprehensively for the States. Even in Appalachia within Blue Cross there are a number of experiments going on. Some plans require that the physicians sign off, but permit the billing clerk to use a rubberstamp. Some have accepted the nurse practitioner and physician assistant and permit them to sign. There is not a uniform practice.

In some States Blue Cross has given provider status to the primary care clinics; in some reimbursement is validated as a physician service.

Mr. FLORIO. I see.

We thank you both for your testimony, and conclude the hearings at this point.

Thank you.

[The following statements were received for the record:]

Statement

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce

August 12,1977

Re: H.R. 8543 - To amend title XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

The American Medical Association submits the following statement relative to H.R. 8543, a bill which would recognize Medicare and Medicaid payment for the services of physician extenders provided through "rural health clinics" and would establish demonstration projects for physician clinics in urban settings and for organized centers offering comprehensive outpatient mental health services.

H.R. 8543 is a modification and broad expansion of legislation introduced earlier this session, and we understand and support the Subcommittee's desire to respond to a need for recognizing Medicare reimbursement for extender services. We particularly applaud the Subcommittee's concern for expanding the availability of services to the rural poor. We are also supportive of incorporating appropriate recognition of extender services as reimbursable under Medicaid.

As you may recall, the AMA has been at the forefront in supporting the utilization of physician's assistants and early recognized their special utility

in medical care shortage areas. In the past we have pointed out the need for legislation recognizing the role of the physician's assistant in serving to "extend" the services of a physician into shortage areas.

To this end we have developed and had introduced legislation in this Congress under which Medicare would reimburse the physician for services performed by his supervised extender irrespective whether the extender performed services at, or away from, the physician's office. We believe that enactment of our legislation would encourage wider use of physician extenders and give proper recognition to their essential nature, which is to extend the physician's services. The extender can provide quality patient care, following proper training in accredited training programs, when he has met any State requirements for provision of services, and when he provides service under the supervision and direction of a physician. The necessity of proper supervision and direction emphasize the essential role of the physician, which is to assure that his extender is properly trained and supervised. The physician must always remain answerable to, and take responsibility for the proper treatment of, the patient. Under no circumstances should this responsibility be delegated to individuals with inadequate training. Both physicians and patients demand quality care. Failure to retain physician direction and supervision would be detrimental to quality patient care in the long run.

While an extender can be advantageous in many settings, the extender is often especially advantageous in rural shortage areas in which no physician is personally available. However, in a rush to provide some services to a shortage area, it would be easy to brush aside proper safeguards. It is imperative to preserve for all patients--including those in rural areas-- a high standard of care.

The bill before you--H.R. 8543--does address certain laudable ends. Nevertheless, as we point out, the bill retains many of the weaknesses of earlier legislation while adding several objectionable provisions not even related to reimbursement for extenders in rural shortage areas.

EXTENDER REQUIREMENTS

The bill defines a "physician extender" as "a nurse practitioner or physician assistant who performs such services as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who meets such training, education and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations".

The condition that the extender meet State requirements is a provision which we support, and we believe that such a provision properly recognizes the primary (and exclusive) responsibility of the individual State to determine the qualifications and scope of the extender's practice.

The bill further defines the physician extender, however, as one who also meets "such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations". We believe that the physician extender should complete a training program, or have experience, meeting the training program standards of recognized accrediting agencies. Compliance with any standards established in States regulating this category of personnel would be sufficient to assure the appropriate training. The federal government should not usurp the State's traditional role of determining practice qualifications nor should the Secretary be given the power to determine the quality of education, experience or training that an individual has received and thus deemed qualified under the program. The language in the bill authorizing

the Secretary to establish standards should be deleted.

We are also concerned that the definition does not appear to recognize what we believe to be the underlying concept of the physician extender, namely, that the extender is actually intended as an expansion of a physician's services, with the necessary close and continued supervision of the extender by the physician which that implies. While there is some language in other provisions of the bill pertaining to general supervision by a physician, there is no clear and unequivocal requirement that a physician should be responsible for supervision of the extender and the services he provides. This responsibility and supervision is necessary to assure quality patient care. The definition of "physician extender" should be amended to state clearly that the extender may perform services only under the supervision of a physician.

RURAL HEALTH CLINICS

Certain portions of H.R. 8543 recognize concepts on which an extender program should be built; however, other portions of the bill are troublesome. While the objective of the bill, ostensibly, is to provide payment for services of the physician extender, the bill would accomplish this by creating a new body of services known as "rural health clinic services." These new services would be, in essence, physician services and physician extender services when furnished to an outpatient of the newly created entity called a "rural health clinic." Any services provided by a "rural health clinic" would be reimbursed out of Part B Medicare funds only to the "clinic", and would be reimbursed on the basis of "80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations . . . ".

The "rural health clinic" itself would be defined as an entity which

complies with all of the following:(1) is primarily engaged in providing rural health clinic services, (2) has, (in the case of a clinic which is not physician-directed) an arrangement with one or more physicians for review by the physicians of all services provided by the physician extender, for preparation of medical orders, for supervision and guidance of the extender and for referral and for advice and assistance in medical emergencies, (3) maintains clinical records, (4) arranges for referral and admission of patients to hospitals, (5) provides for development of governing policies relating to services with advice of a group of professional personnel (including at least one physician and one extender), (6) provides for a physician or physician extender to be responsible for execution of policies relating to services, (7) provides directly for routine diagnostic services including clinical laboratory services (as determined by the Secretary), (8) has drugs and biologicals available for emergency treatment (as determined by the Secretary) and complies with State and federal requirements for storage and dispensing of drugs and (9) meets such other requirements as the Secretary requires.

As a further limitation, such a clinic could only be one which (1) is located in "a rural area designated by the Secretary as having medically underserved populations"; (2) agrees not to charge for items and services except for any deductible or coinsurance amounts; (3) employs a physician extender; and (4) is not a rehabilitation center or a facility primarily for the treatment of mental diseases.

We note that this bill, unlike predecessor legislation, does not specifically prohibit the reimbursement for services of an extender provided in a physician-directed clinic. However, in order for a physician-directed clinic to be eligible for reimbursement, it would have to meet the otherwise applicable provisions of the definition of "a rural health clinic."

In fact, the definition itself points out a glaring inconsistency allowing payment exclusively to a "clinic". By what reasoning should a facility be reimbursed for what must be identified essentially as physician's services? The fundamental concept in the bill is that the extender is in fact providing an extension of "physician" services, yet the provisions of the bill in this regard strain logical analysis by limiting payment (out of Part B on the basis of cost) to a specially recognized facility-- the "rural health clinic"--for physician services performed by a non-physician.

We believe that it would be detrimental to encourage through federal reimbursement of an entity this provision of physician services by non-physicians. The entity created by the bill is not licensed by the State to practice medicine nor can it provide services other than through its employees. However, there is no requirement that a physician be an employee of the entity, nor that a physician be available to supervise the extender.

Furthermore, it is difficult to conceive of a situation in which a physician would operate a "rural health clinic". In fact, disincentives for participation by physicians are contained in the bill. If a physician did agree to operate such a "clinic", he would be limited to reimbursement from Medicare for his own and his extender's services on the basis of "cost" determined by the Secretary. The patient could be charged nothing more beyond coinsurance and deductible. Moreover, physicians would be reluctant to allow the extender to participate in preparing policies governing the services provided,particularly where the extender alone is responsible for carrying out these policies.

In addition, the bill does nothing to encourage physicians to make greater use of physician extenders outside of the so-called "clinic" setting. If in fact it would turn present physician satellite settings into "clinics",

the bill could well be directly counter-productive.

Of great importance also is the failure of the bill to allow reimbursement for extenders employed directly by physicians outside any "clinic" setting as defined by the bill. We believe that this failure, by creating a distinct bias in favor of allowing reimbursement only to a "clinic", will hinder the desirable expanded use of the physician extender.

RESPONSIBILITY FOR EXTENDER

As we pointed out earlier in our statement we have long supported the use of the physician extender. However, we believe that this person should be utilized as originally intended, i.e., as an extension of and assistant to the physician with the physician remaining primarily responsible for the extender's patient care functions.

As the bill is written, however, it is unclear exactly who is responsible for the actions of the extender. Although the definition of the extender requires "supervision" by the physician, the bill in establishing requirements for the clinic, states that policies are developed 'with the advice of . . . . a group of professional personnel, including one or more physicians and one or more physician extenders, to govern the services" provided by the clinic (Emphasis added). Moreover, it provides that a physician or extender may be "responsible for the execution of such policies relating to the provision of the clinic's services".

We question the sufficiency of the apparently limited role of the physician with respect to the provision of medical services by the "clinic".

Such provisions in the bill could allow the extender to be responsible for executing the policies of the "clinic" in regard to services while the policies are developed only through "advice" of the physician. This language of the bill does not clearly require close supervision by the physician of services provided by an extender. Furthermore, an authority allowing the non-physician to assure that he is carrying out the policies of the clinic in regard to medical services is highly inappropriate and could well lead to federal reimbursement for services of an extender which would not be otherwise reimbursable outside the "clinic" even if performed by a physician.

PAYMENT INCONSISTENCY

Because payment under this bill is limited to the "clinic", the extender's services would be paid in the "clinic" setting,but payment would continue to be denied when services are furnished in another setting.

For example, under present HEW interpretations concerning Medicare, the only way in which the extender's services can be reimbursed is if they are performed "incident to" a physician's professional service. Furthermore, under the strict Medicare interpretation this:

> ". . . limits coverage to the services of nurses and other assistants that are commonly furnished as a necessary adjunct to the physician's personal in-office service. Thus, the performance by a physician's assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met."

Now, however, H.R. 8543 proposes to reimburse for services that are not 'incident to' a physician's services. While we believe that services of an extender should be reimbursed, we do not understand the rationale for allowing such reimbursement to a facility for services of an extender while those same services would not be reimbursable when performed under the direction

or supervision of a physician in his own office or in other settings other than in the "rural health clinic".

We believe that the bill as presently written would create many unintended problems which could adversely affect development of quality care.

MEDICAID RECOGNITION OF EXTENDER

H.R. 8543 would modify earlier legislative proposals by including in recognized reimbursement under Medicaid the new "rural health clinic services". The terms "rural health clinic" and "rural health clinic services" would be defined as they are for Medicare, and payment to the "clinic" under Medicaid could not exceed the amount payable under Medicare. A "clinic" qualified under Medicare would be eligible also for reimbursement under Medicaid.

We indeed support, as we pointed out earlier, the concept of reimbursement under proper circumstances for services performed by extenders. We believe that both Medicare and Medicaid should recognize such reimbursement. However, the objectionable provisions of the proposed Medicare provisions are equally applicable to the provisions of Medicaid since the latter would incorporate the Medicare limitations.

In addition, the Medicaid provisions propose two new concepts which would compound the detrimental effect of the "clinics" on health care. First, Medicaid would reimburse (in addition to those defined "rural health clinic services") "any other outpatient services which are offered by a rural health clinic." Under this provision, any service in the State plan when offered by a "clinic" would be reimbursable to the clinic at the reasonable cost level determined by Medicare. These services could include many other than physicians' services. Thus, the original argument for recognizing services of extenders in order to extend physicians services has resulted in the creation of a specially recognized "clinic" and then further twisted under the

Medicaid proposal by allowing reimbursement to the "clinic" for other than physician or physician extender services to include any outpatient care under the State plan. We believe that this new concept debases the intended extension of physician services and could result in unlimited funding for every service available under Medicaid on an outpatient basis. This provision should be stricken.

Second, the new Medicaid proposal limits the individual's free choice of facility or physician presently assured under the Medicaid law. The new proposal would authorize an exemption in a State plan that "only provides for rural health clinic services only in rural areas". While the Subcommittee may intend merely to require a State to offer such services only in rural areas without risking State plan noncompliance with otherwise applicable law, ambiguity exists in this phrase in its use of the word "only" twice. It appears that the interpretation could be maintained that a state plan may require, in rural areas, that Medicaid services can be provided only through "rural health clinics". This provision under such interpretation would be extremely objectionable. The provision could in effect require all persons in a rural area receiving Medicaid in their area to utilize the "rural health clinic". As we have pointed out above, such "clinics" could utilize extenders having little physician direction or supervision, could provide any outpatient service recognized under the state plan, and would have arrangements with hospitals for admissions of patients.

We believe that such authority could readily result in the creation in rural shortage areas of a type of "Medicaid mill" primarily funded and utilized by Medicare and Medicaid, with Medicaid patients forced to make use of the clinics if seeking Medicaid outpatient services, and primarily staffed, operated, and controlled by non-physicians. We believe that this would lead to two classes of care in a community--those in the mainstream of

medical care and those forced into special "clinics." This is not the goal of quality medical care. The potential for undesirable development of two classes of care should not be risked. This provision should be stricken.

DEMONSTRATION PROJECTS

The bill provides for two new projects for demonstrations under Medicare.

The first of these projects (with results and recommendations to be reported by the Secretary to Congress by January 1, 1981) would be directed toward reimbursement of "services provided by physician-directed clinics in urban medically underserved areas" and for services of extenders employed by the urban clinics.

The provisions are ambiguous and include several contradictions. For example, demonstration projects are to reimburse on a cost basis urban clinics employing extenders, yet the demonstration is to evaluate the differences between reimbursement on the basis of cost and fee-for-service; any urban clinic project is to be reimbursed on a cost basis, yet the demonstration is to identify the "appropriate method" of determining compensation of physicians on a cost basis; projects are to be for clinics in "urban medically underserved areas", yet the projects are to define such clinics and must identify appropriate criteria for designating "urban medically underserved areas." Reimbursement would be from both Part A and Part B of Medicare.

We believe that demonstration projects for reimbursing extender services are appropriate, but we believe this proposal is defective and unnecessarily ambiguous in several respects. One of the most fundamental defects of the proposal is the potentially self-defeating suggestion that physician services can be generated in a shortage area by further limiting physician reimbursement to "costs". A more appropriate approach to demonstration projects would include reimbursement of physicians (irrespective of

whether located in a "clinic") on a fee-for-service basis at usual and customary levels.

Furthermore, the proposal in the bill is so vague that implementing regulations could well determine the results of the projects. There are no criteria or definitions as to "urban medically underserved areas", clinics, physician extenders, physicians, cost basis or any other term in this section, nor is there any incorporation by reference of any other provision of the bill or of existing law.

These provisions should be deleted.

The second new project authorization would recognize Medicare reimbursement (out of Part A and Part B) to "organized centers offering comprehensive outpatient mental health services." A report of the results with recommendations would be provided by the Secretary to Congress by January 1, 1981.

The projects would allow the Secretary to evaluate various methods of reimbursement, relative effects on utilization resulting from varying definitions of and limitations on services, the definition of a center, the definition and qualifications of individuals providing services, and other changes affecting reimbursement of mental health services under Medicare.

The language of the provision is also vague and uncertain in several areas and raises questions . Most basic is the potential effect of these provisions on present limitations on outpatient mental health care under Medicare.

We believe that many aspects of these projects can be carried out under existing authority. In the absence of clarifying language, these provisions should be deleted.

CONCLUSION

The AMA is indeed sympathetic with the problem which the Subcommittee has before it, and we recognize the objectives of certain provisions of the legislation. However, the bill emphasizes the difficulties which arise when the Medicare and Medicaid programs are sought to be used and tailored to reach what is perceived to be very limited and special situations. However, once a payment system is provided and an entity created and recognized for payment purposes, proliferation will certainly follow. It is important that proper medical safeguards be provided. While we recognize also the exigencies that pertain to certain rural situations, we must be careful to avoid a duplication of problems, as has come to light concerning quality and propriety of services in the so-called Medicaid mills, generally identified in the past with urban areas.

We have already pointed out that the bill would have many undesirable effects on quality care. It would establish new entities to receive payment on a cost basis for services provided (either by a physician or by an extender) while not clearly providing for appropriate physician direction and supervision of, and responsibility for, the extender. It could in effect allow non-physicians an improper role in determining and carrying out physician services. It could create and encourage two classes of care in Medicaid. It would create projects further limiting and discouraging physician services in urban areas. It would create ambiguous authority for projects in mental health services under Medicare. All of these and other issues are created in the bill and should be satisfactorily addressed and modified.

Aside from the many issues created by the bill, there remains the desired intent to provide for payment of physician extender services. If the

Medicare and Medicaid programs are to recognize payment for services of physician extenders, discrimination should not be created against the fundamental situation out of which the physician extender movement developed. Proper recognition and reimbursement must include the basic concepts of: (1) proper supervision and control by the physician of a properly trained physician extender; (2) retention of responsibility in the physician for the services performed by the extender as evidenced by the billing for the services in the name of the physician, and (3) compliance with state requirements. If these principles are adhered to, the use of physician extenders would be encouraged in shortage areas. To this end, amendment to the Medicare law giving recognition to the true nature of the extender's service would be more appropriate than creating in Medicare and Medicaid a new entity--the "rural health clinic"--in order to recognize the extender's service. A simple amendment to include the extender's service. A simple amendment along the lines that we suggest would foster the development of the original concept and help provide quality care in shortage areas.

Before closing we must raise the question as to whether sufficient experience has been accumulated by Medicare to justify the unqualified approach of this bill in full recognition of the "rural health clinic". Will cost be reasonable for the Medicare population or will Medicare funds be required to underwrite a disproportionate share of "clinic" costs? Has it been established that reasonable cost reimbursement will not result in costs greater in many rural situations than under fee-for-service for services furnished by physicians? In our view presently ongoing experiments in reimbursement of extenders should be completed and evaluated before a widespread program is undertaken.

The AMA stands ready to assist the Subcommittee in development of appropriate legislation in lieu of H.R. 8543.

Accordingly, H.R. 8543 should not be adopted without substantial amendments reflecting the above views.

AMERICAN HOSPITAL ASSOCIATION
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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
ON H.R.8543, RELATING TO MEDICAID PAYMENTS TO RURAL CLINICS
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

August 8, 1977

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. The Association represents over 6,500 health care institutions (including most of the hospitals in the country; extended and long-term care institutions; mental health facilities; and hospital schools of nursing), and over 24,000 personal members. We appreciate this opportunity to share our views and recommendations on your bill, H.R.8543, which requires State plans for medical assistance to include as benefits certain services rendered in rural health clinics. We support the intent of this legislation, although we are concerned with regard to the potential impact of using nonphysician providers in less supervised settings. We would like to offer for the Subcommittee's consideration some constructive suggestions for improvement of the bill.

Background

The American Hospital Association has long recognized the need for innovative use of new and existing health care professionals to provide needed health care services in areas where primary care physicians are either unavailable or present in insufficient numbers to satisfy medical care needs. The AHA has encouraged the training and appropriate use of such health care personnel in order to make health care services more widely accessible, to extend the services of physicians by utilizing their time more efficiently, and to enhance the quality of medical services.

We have also strongly encouraged the development of training and experience requirements to assure that quality health care is given when provided by nonphysicians. The Association is one of the founders and participants in the National Commission for Certification of Physician Assistants along with 17 other health care organizations. We have supported the use of these health care professionals in our hospitals and have disseminated recommended institutional procedures and guidelines for physician extenders in the hospital setting.

The Congress has also recognized the importance of the effective and efficient use of our health manpower resources. Under authority of the Health Professions Educational Assistance Act, which was authored by this subcommittee, funds are provided to schools of public health and allied health as well as scholarship and loan programs for students in these programs. Training programs of the military services have also been an important source of qualified nonphysician health care professionals.

We would like to make a general observation at this point which is designed to facilitate discussion of this subject. We believe there is some confusion regarding the definition of physician extenders which stems in part from the lack of a generally accepted terminology. While we agree with the language provided in Section(a)(3) of H.R.8422, the Ways and Means Committee reported bill, we would recommend the use of the term "nonphysician primary health care provider" as a generic substitute for "primary care practitioner." This terminology is, in our view, more appropriate in describing the category of health care professionals other than physicians who may be utilized in rural health clinics.

Need For Reimbursement Modifications

In some rural areas of the country clinics have been established to provide certain primary care and first aid services to people who otherwise have no immediate access to

such services. These clinics are operated frequently without the benefit of a physician on site to supervise the services of these nonphysician providers. Currently, 27 States have opted under Title XIX to provide reimbursement for such services. Clearly, there are many areas of the country where financial support through the Medicaid program is needed to make possible the continued operation of such clinics.

Mr. Chairman, your bill makes changes to Title XIX of the Social Security Act which would :

- require all State plans for medical assistance to provide these benefits;
- mandate payment of reasonable cost for provided services; and
- facilitate certification of these facilities through the use of existing certification standards under Title XVIII. Moreover, this legislation permits a State to limit this new benefit to health clinics in rural areas only without falling out of compliance with federal requirements.

It is, of course, the intent of H.R.8643 to revise the reimbursement provisions of the Medicaid program with respect to the payment for services rendered in these settings. In all cases we strongly recommend that reimbursement for services provided by rural clinics be on the basis of reasonable costs related to providing such services. We would, therefore, oppose granting the Secretary of HEW the authority to approve State plans with alternative systems of reimbursement which depart from this important principle of Medicare reimbursement.

In view of the fact that nonphysician health care providers are rendering services in some rural areas which lack other health resources and that there exists a problem of reimbursement in these situations, we support H.R.8543. Nevertheless, we are concerned about the lack of adequate physician supervision in these settings. Therefore, we would

recommend that reimbursement of nonphysician primary health care providers be permitted only as long as there is not available sufficient physician direction which would otherwise permit payment under existing provisions of the Medicaid program. Further, we believe that the provisions of H.R.8543 should be considered experimental with an evaluation of the quality of services provided carried out within one year after the date of enactment to insure that these amendments to Title XIX of the Social Security Act serve their intended purpose.

We would now like to summarize our specific recommendations which we believe will improve the provisions of H.R.8543.

1. Reimbursement under Section 1905(l) of Title XIX for nonphysician primary health care services in settings that are hospital-based or operated should flow through the hospital reimbursement provisions under Medicaid.

2. Reimbursement under Section 1905(l) for nonphysician primary care providers employed by physicians in a nonhospital clinic or facility should be made to the employing physicians.

3. Nonphysician primary health care providers in hospital-based or operated clinics must be subject to the rules, regulations, and procedures of the institution with respect to the scope of services provided by such individuals.

Mr. Chairman, we appreciate this opportunity to express our views and recommendations before your Committee on H.R.8543.

NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS
2233 Wisconsin Avenue, N.W., Washington, D.C. 20007

Statement Submitted to

Health and Environment Subcommittee
Committee on Interstate and Foreign Commerce
U.S. House of Representatives

Concerning

HR 8422 and HR 8543,
Clinic Services under Medicare and Medicaid

July 28, 1977

This statement is submitted on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 365 community mental health centers, most of which receive federal grants under the CMHC Act, and another 211 agencies which are developing CMHC programs or which have a direct interest in community mental health.

Under Public Law 94-63, community mental health centers are provided limited funding over an eight-year period with the expectation that additional monies will be raised from state or local government sources, various third-party payments, fees and charities. Under Section 206(c) of PL 94-63, centers applying for federal grants are specifically required to assure that they will develop a plan for adequate financial support from other federal and nonfederal sources so that the CMHC will be able to continue to provide comprehensive mental health services when categorical grants are reduced or terminated.

PL 94-63 is also quite specific regarding where some of these alternative funds are expected to come from; Section 206(c) also requires CMHCs to collect appropriate reimbursement for services to beneficiaries under Titles XVIII and XIX of the Social Security Act (Medicare and Medicaid).

Thus under the CMHC Act all centers are expected to obtain maximum third-party payments, and specifically to seek out Medicare and Medicaid funding. Yet federal law now makes it almost impossible for CMHCs to be reimbursed for significant services under Medicare and places barriers in the way of CMHCs' collecting Medicaid payments.

Medicare and CMHCs

Federally-funded CMHCs are now unable to qualify as providers under either Part A or Part B of Title XVIII unless they are directly operated by a provider hospital, in which case the CMHC program comes under the auspices of the hospital and bills through the same provider number. However, currently only about 15% of federally-funded centers are operated by a hospital, while 62% have agreements with a provider hospital for the hospital to provide inpatient care to CMHC patients. The problem is most acute, then, for outpatient services -- which is the primary service that CMHCs provide. Provider status under Part B is now denied to about

85% of the CMHCs, which can thus collect for only extremely limited reimbursement through physician fees for service.

A further restriction is the definition of physician supervision which makes it impossible for many of the CMHC services to be reimbursed. At the present time there are insufficient psychiatrists to supervise all community mental health care, even if that were desirable. But in fact, it is not necessary, practical or desirable to require that a psychiatrist or physician be present when all care is provided. Not only is this unworkable because of psychiatrist shortages, but it is unwise since much of the psychological treatment required by CMHC patients can be provided by other members of the CMHC professional treatment team at less cost.

Within an organized setting, such as a CMHC, controls on the appropriateness of care and the quality of service rendered can be made by setting conditions for operation of the provider agency, including peer and other reviews. Thus, the provider agency can be held accountable for ensuring that services are appropriate and of high quality and that patients' rights are protected. Lines of responsibility and accountability in such CMHC providers should be clear. Once such controls on quality care are in place, it is not necessary or desirable to include in the federal statute conditions regarding the day-to-day operation of the programs, especially the appropriate roles of members of their professional staff.

Until CMHCs are eligible for cost reimbursement for services furnished by all mental health professionals (not only services of MDs) to Part B beneficiaries, it is impossible for them to recoup the necessary non-categorical grant funding for services to those over 65. Currently, individuals over 65 represent only 4% of CMHC patient loads; these reimbursement difficulties under Medicare are preventing CMHCs from redressing this imbalance and meeting the mandate of PL 94-63, Section 201(b), that they provide comprehensive services to elderly persons.

Medicaid and CMHCs

The problems under Medicaid are a little different, but the effect in many states is much the same.

Medicaid limits reimbursement for inpatient mental health services provided by psychiatric hospitals (with which many CMHCs have agreements for provision of inpatient care). Currently, only those under 21 or over 65 years of age are eligible for such services, at the state's option. Thus, reimbursement for inpatient services to a major proportion of CMHC patients is frequently not available. On the other hand, such reimbursement is available for CMHC patients if the center has contracted with a general hospital for provision of such services, instead of with a psychiatric hospital. Yet in both instances the CMHC program is responsible for the patient's admittance and care.

As under Medicare, those CMHCs operated by a hospital are eligible for reimbursement for outpatient services; free-standing centers operated by other public or private nonprofit agencies are eligible for such reimbursement only if the state chooses (a) to include the clinic services option in its state plan and (b) defines a clinic in such terms as to permit CMHCs to participate.

Currently, twelve states do not include the clinic services option in their state plan. These states are: Alabama, Arizona (which has no Medicaid), Colorado, Florida, Iowa, Mississippi, Missouri, North Dakota, Oklahoma, Rhode Island, Texas and Wyoming.

Of the states which do include clinic services in their plans, many place limits on agencies which can participate. One practice in many states is to limit eligibility to clinics run by counties (thus excluding many federally-funded private non-profit programs) or to clinics operated by hospitals (excluding all free-standing programs).

Many states place limits on the number of visits authorized; rates of reimbursement, which are frequently lower that the actual cost of delivering the services; the method in which services can be delivered -- i.e., prior authorization, reimbursement only for physician services or for physician-directed services, etc.

These limits have the effect of reducing potential payments to CMHCs for services to Medicaid beneficiaries. Nationally, CMHCs receive approximately 10% of their revenues through Medicaid. Yet in states which offer good CMHC medicaid coverage and adequate rates of reimbursement, this percentage reaches about 30% of the CMHC's budget. Since the great majority of CMHC patients are low-income persons, many are eligible for Medicaid. However, until payments for services to these patients can be received, it is impossible for centers to replace the federal categorical grant funding once it is terminated.

HR 8422 and HR 8543

HR 8422 and HR 8543 would address the problems of CMHCs in Part B of Medicare by authorizing a major demonstration project to assess the impact of giving CMHCs provider status and reimbursing them on a cost basis for outpatient services. This demonstration, while it does not immediately improve the reimbursements to most CMHCs from Medicare, is a major step and one which will enable HEW to determine how best to draft language which would provide Part B reimbursements to appropriate CMHCs and other comprehensive outpatient mental health programs. NCCMHC endorses the idea of this demonstration, and urges the subcommittee to make no changes in that section of HR 8422.

With regard to Medicaid, HR 8543 would amend Title XIX to require states to reimburse rural health clinics for services on a cost basis. The definition of such clinics does not specifically include mental health centers, and the language applies only to programs serving rural medically-underserved areas.

NCCMHC urges the committee to amend this section to ensure that all federally-funded community mental health centers would be included under Section 2 of HR 8543. Since PL 94-63 both requires and necessitates CMHCs' collecting Medicaid payments, this contradictory language in HR 8422 and HR 8543 (which excludes CMHCs from the proposed improvement in clinic services benefits) is in direct conflict with policies espoused by this subcommittee in PL 94-63.

NCCMHC urges your prompt attention to this problem.

STATEMENT OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

Mr. Chairman and Members of the Subcommittee:

The National Federation of the Licensed Practical Nurses wishes to thank the chairman and members of the Subcommittee for this opportunity to comment on the concept of 3-party reimbursement under Medicare-Medicaid.

We are the professional organization that represents Licensed Practical Nurses. Currently there are more than 550,000 in the United States. We have a keen interest and a great concern for those in need of health care services. We have observed first hand the needs of the medically deprived who live in underserved areas of our country. We have watched as some of these health services have deteriorated because of the current federal policy of not reimbursing providers with Medicare funds and are fearful of the survival of some health services if there is not a change in policy.

The National Federation of Licensed Practical Nurses intends to use this opportunity to emphasize our strong support for HR 8543 with some modifications. You have heard the testimony and statements of many knowledgeable people. We are sure that you are aware that the administration has proposed, in the 1978 fiscal budget, that $25 million be used to provide this Medicare coverage of services provided by nurse practitioners and physician's assistants in primary health clinics. You also have available the reports of the Rural Development Subcommittee field hearings and of your colleagues on a subcommittee of the House Ways & Means Committee. The Department of Health, Education and Welfare has publicly stated that they too support such legislation.

Our organization would like to publicly go on record favoring the passage of HR 8543 to correct the inadequate coverage of third party reimbursement and, indeed, would urge the subcommittee to give serious thought and consideration

to further extending this coverage to include the services that are provided by educationally prepared Licensed Practical Nurses, Nurse Practioners and physician's assistants.

As members of this subcommittee are no doubt aware there has been steady progress and upgrading of the education and professionalism of Licensed Practical Nurses. The Licensed Practical Nurse profession has proven its worth in the pragmatic world of relieving human misery and suffering. We have been schooled in the basics of health care and nursing techniques in both the field and the classroom and exercised our training in various health facilities.

Our members are successfully engaged in many rural health clinics, especially in home health care situations, and have first hand knowledge of the present deficiences in the law, and therefore applaud the intent and mandates of HR 8543 as it would amend Title XVIII and Title XIX of the Social Security Act. Many of the health care situations in which we are involved are staffed by Licensed Practical Nurses and our usefulness could be magnified by the extension of coverage to include also the services that we provide.

With the staggering work load of many physicians and their apparent scarcity in rural and other underserved areas, it would seem that other health professionals would be logical and frugal substitutes. These clinics are under the supervision of physicians and are able to make better use of the sophisticated means of communications now available. Care administered by health providers is often dictated by specialists who are many miles away. If we have these avenues available and can use them to lessen a medical problem or save a life, we ought to be progressive enough to make them legislatively

and economically feasible and be able to implement them efficiently. There is always the danger that we will shun progress because we neglect to take a simple step or two that will align the rules with the needs and solutions.

Modern day practical nursing has become more sophisticated in recent years. Our profession has come a long way since the time that just anyone could be called into a sick room or hospital.

In 1977 we look at even a most humble rural health center and see it as a place where preventive medicine is routinely practiced, where treatment prescribed by a physician can be carried out according to his dictates but does not necessitate his presence. The degree of excellence of the practical nursing course in accredited schools prepares dedicated people for their chosen occupation.

The federal government is making progress in focusing on the problem of serving the health needs of those in underserved areas. This bill will go a long way to make that task easier.

One cannot fault the physicians for this situation because there are so many noble, bona fide opportunities for them to serve a variety of health needs. While we see the need of the few in isolated areas or the many in inner city ghettos, there are also the many in suburbia to be served as well as the research and teaching to be done. This is exactly why the National Federation of Licensed Practical Nurses can wholeheartedly urge the passage of this measure. It not only permits the physician to work where he or she might be most needed but would also allow more physicians to share their time and expertise with other health providers who work in health satellite units.

This is one economical and efficient way to dote to the perennial shortage of patient-serving personnel.

If this bill is not passed, we fear the almost complete collapse of this fine network of medical clinics. Many of these federally established satellites will soon be forced to operate on their own as their seed money will no longer be granted. Also, if the patients are not reimbursed by Medicare they will either not be able to pay for these needed services or, worse, they will discontinue receiving nursing care.

Likewise, if this measure is not passed, new costs will appear--such as the dollars needed for transportation to take patients to facilities where Medicare will furnish services. Added to this will be the intangible cost in time and discomfort and treatment involved in transporting an ill person. It scarcely needs to be pointed out that there would be a toll in insecurity for people who may be aged and bewildered, and in fear of the unknown and unfamiliar. Also it would be a traumatic experience for some to travel from their parochial surroundings. One can only speculate how many of these patients would simply ignore their health problems and cease to seek advice and treatment.

In the chain of events that may occur in unsupervised home treatments, patients would suffer dire results if they are given, for instance, a large supply of medication and consume it at an over-accelereated rate. Also other types of medication that could be administered only in a local satellite clinic might not be available to the average citizen. The new and needed approach of permitting third-party payments seems to be a sensible approach to a problem that already seems to be solvable with the

availability of skilled and educationally prepared health providers.

The National Federation of Licensed Practical Nurses urges the passage of HR 8543. We further urge the subcommittee to begin thoughtful and serious consideration of including the services of Licensed Practical Nurses who are prepared to deliver quality health care whereever and whenever needed; such services should be considered under Titles XVIII and XIX of the Social Security Act.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

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