Podcast Transcript

Nursing Reimbursement: The history and potential future

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Dr. Candace Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. PIERCE: strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Host: Robin McCormick, DNP, RN

Dr. Robin McCormick DNP, RN has been a nurse leader for over 23 years in nursing practice, leadership, management, and education. Dr. McCormick earned a Doctor of Nursing Practice (DNP) from Troy University in 2018, a Master of Science in Nursing degree from University of South Alabama in 2007, and a Bachelor of Science in Nursing (BSN) degree in 2000 from Troy University. Dr. McCormick has published and presented on topics relevant to nursing practice and education on the local, national, and international levels. With a passion for improving community health outcomes, Dr. McCormick has a research focus on mental health, maternal-child outcomes, and community health.

Transcript

Candace Pierce: I'm Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Now this podcast recording is going to be a little bit different than how we normally structure our podcasts. And joining me for this discussion is my amazing colleague, Dr. Robin McCormick. Robin, thank you for being here with me today on the podcast.

Robin McCormick: So I'm glad to be here.

PIERCE: And we're really going to be discussing nursing reimbursement and where we see it headed in the future. And what really kind of brought this to our attention is last year, there was a commission for nursing reimbursement that stood up. And so it really made me start looking and thinking about where it was in our history and where are we going? Do you ever think about any of that? I didn't think about it until I saw the standup of this commission. What about you?

MCCORMICK: Yes, I really started looking at it then too. I think that nursing time passes, and we forget about where we came from.

PIERCE: Yes, absolutely. And that's where I really started looking at historically, where did we come from and where are we headed and what's happening? Why did we need something like this to stand up? And so what I found is historically nurses were compensated in a few different ways before we had this establishment of modern healthcare reimbursement models. And so, you know, in the early 1900s, nurses mainly worked as private duty nurses, really providing direct care in patients' homes. And it's interesting to think about where we are now. I'm so far removed from that, and so through this reimbursement model, what we saw was that they were charging patients directly for their services, basically allowing nurses to run these independent businesses and negotiate their fees in order to go into these homes. And really it gave a lot of financial independence and professional autonomy to these nurses in the early 1900s. And for me to even think about that today.

MCCORMICK: I know, and when you think about too, that the nurses back in the day, a lot of them were primarily women. And then back in those times, it was a great way for them to have financial independence where they might not have gotten it from other jobs.

PIERCE: Right. And I just wonder how much freedom they had as far as like, when I'm going to go see these patients. And, you know, I don't, I don't actually know how much they were charging back then and what that would equate to today. I couldn't really find an answer to that, but I just found it interesting — the autonomy that they had, because you don't really see a lot of that autonomy today. So then, yeah, yes, for sure. But then we started seeing the rise in hospitals expanding and then we started to see the formalization of healthcare and how it was delivered. And so that's when nurses were increasingly more of them were employed by these institutions, these hospitals. And so initially hospitals really recognized the value of nursing care. And I didn't know this, but it was billed separately. Similar to how they bill physician services separately, nursing care was billed separately.

MCCORMICK: I didn't know that. That's very interesting.

PIERCE: Yeah. And then it was by the 1930s where we started to see the rise of health insurance and changes in these hospital financial models where nursing services were no longer being billed separately. Instead, they became like an included in that overall hospital room charge. Much like we see housekeeping services in a hotel. It's part of that overall charge. And this shift that we saw was effectively bundling nursing services into the general hospital costs, which really started to diminish the visibility and the perceived value of nursing care as that distinct and billable service like physicians still are today.

MCCORMICK: I know, and it's really sad. I found a statistic I thought was very interesting that was from the National Nurses United, which I believe is like a policy group for nurses, but they said that 90% of the care given to patients in the hospital is done by the nurse. It's probably not too far off. I was in the hospital yesterday taking care of patients, and I would say that we are that person that's right there at the bedside. It's just interesting to me that we provide so much, we're just bundled into the whole.

PIERCE: Right, and how many hats we see nurses wearing today, you know, because they do, we wear the housekeeping hat a lot of times too. So, but unfortunately, when this shift started to happen, really that sets the tone of the historical context for these ongoing discussions and efforts to try to reform nursing reimbursement models today, because that's where we started to not be seen anymore. I guess we became more of, I get, you know, we kind of became invisible when it came to pay. So now let's move to the 1960s. And again, we saw a significant shift in healthcare reimbursement in the 1960s, which led to separate reimbursement of nursing services from physician services. So this change was largely driven by the introduction of Medicare and Medicaid, which, you know, when those were stood up, they really transformed healthcare in the United States. Good things and bad things, but that was really a huge shift in healthcare reimbursement. And these programs, they were providing federal funds to cover healthcare services, which included nursing care, but it also established that framework we see today for third party payments. So, you know, before the shift, nursing services were typically bundled with other hospital services like room and board charges, which made it really difficult to recognize and reimburse nursing care as a distinct service like it was in the early 1900s. And it really started to show how this bundled model really just obscured the value of nursing and you couldn't see it on an itemized hospital bill. So there was no visibility that really valued nursing service. So we see the separation of payments for physician services from other healthcare services, including nursing, and then that allowed for the development of these distinct reimbursement models that we see still today. Also, when Medicare and Medicaid stood up and when it was introduced, it also really started to establish those specific billing codes and those reimbursements that we see for nursing care today, which has helped some. It did help some when it brought back a little bit of visibility through those billing codes to really highlight some of those unique contributions that we bring to patient outcomes. But again, there's still a lot of challenges today in equitable reimbursement for nursing services.

MCCORMICK: I mean, basically, the billing codes, I mean, they do recognize some of the nursing care, but essentially with those, you still are better off. The less you spend to take care of the patient, the more money you're going to make. And so that really doesn't value the value of nursing.

PIERCE: Right, and we know that those billing codes are not going to account for that statistic that you just shared of 90% of the care of patients in a hospital comes from nursing, you know. So the introduction of Medicare and Medicaid in 1965 really impacted that federal funding for healthcare services. And what we know is that some of the biggest challenges that nurses have faced in gaining reimbursement recognition is that nurses are not seen as independent providers. You know, we have this physician-centric payment model that is still very popular today with our insurance companies. And so that does not recognize nurses as independent providers, even though we do have some autonomy in how we take care of patients, especially our advanced practice nurses. So they are still struggling with this with independent payments because of that physician-centric model. We're also seeing other barriers, which include like state-level restrictions on nurse practitioners. We don't have the lobbying power that physician organizations have, which also creates some of the challenges in order for us to advocate for ourselves. And also like trying to prove cost-effectiveness in healthcare financing. It's been made really difficult as well.

MCCORMICK: Yes, and I think part of that, you know, the lobbying, as many nurses as we have in the United States, one thing that we just don't do well is lobby for ourselves. We don't unite as much as you see with the physician population.

PIERCE: Yeah, and we advocate so well, I feel like for our patients, and this is my personal opinion, but as a profession, I see that we advocate for our patients so well and we are so, we want to provide top, high-quality care to them, but we don't do well advocating for ourselves. We don't do well taking care of ourselves either. We can tell you what to do all day long, but we don't do well at taking care of ourselves and advocating for ourselves. And so I definitely see where we, that is, I feel like a really big challenge for our profession.

MCCORMICK: I think part of that comes from, too, nursing. They tell you nursing is a calling and so if it's a calling then you just got to do all these things no matter how you get treated. So take care of your patients because that's what your job is kind of. That's your calling and then we forget that yes, it is, but it's my job and that I deserve to be reimbursed for the value that I bring to that patient's care.

PIERCE: Absolutely. We bring a lot of things to the table that, I mean, you have insurance companies that are just seeing a bill or just seeing a billing code, but do they really see what we are bringing to the table, what we are doing and how we are caring for our patient? You know, I really, I found it so sad whenever I was going through the history of this, when I saw, you know, back in the 1930s where all of a sudden all of the things that

we did and all the things that we do, nobody sees it when it comes to payment. Yes, patients see it, patient families see it. You know, I'm sorry but hospital leaderships, they have to see it. There's no way that they cannot see that. But then to know how we are devalued, our contributions are devalued when it comes to the finances and the pay and even how much we receive in pay.

MCCORMICK: And it's hard and I know just from the hospital perspective of the business is it's just such a tight budget that it's easier to work a little short. It's easier to not highly compensate nurses because you got to stay open for business. And I'm glad I'm not on that side. But I think they forget that that high-quality care of nurses, that's what gets your patients home faster. And that really is what overall reduces the price that they're having to pay in addition to just the benefit that it provides the patients to get that high-quality care.

PIERCE: Yes, I mean we are an important piece of the puzzle as far as patient care. And so I want to go back to talking about the physician-centric payment model. Are you familiar with that model?

MCCORMICK: Somewhat, yes.

PIERCE: Yeah, well, basically it's exactly what it says, physician-centric. And so really that model just doesn't recognize nurses as independent providers. Even our advanced practice nurses, even those that practice independently, have autonomy, but are not necessarily seen as independent providers, only physicians. You know, pardon me if I'm sitting at the table, I can understand part of this when it comes to APRNs. Because we didn't go to med school, we didn't have residency, but we still, and evidence shows, research shows that we still bring a lot to the table, effective patient care, high-quality patient care, and the ability to do a lot of what physicians do. So I struggle a little bit with this because I have a little piece of me that understands what they're saying, but then it's also, but look at the data, look at the research.

MCCORMICK: So, the data and research, and then one more statistic. I love statistics so sorry, but I was an American Association of Nurse Practitioners member, and I think it was a couple years ago they came out with this statistic that nurse practitioners save health care dollars, the health care system in the US, eight billion dollars a year. Think about eight billion dollars a year and that they're reimbursed differently than doctors, but they do provide a benefit. And I think sometimes we got to remember that the purpose of the nurse practitioner as a provider and the purpose of the physician, even though they can do some of the same things, they could really value that nurse practitioner role as that patient's primary provider for the stable patient, the patients that just need that annual visit and knowing that, of course, if they needed a higher level of care that they could be referred to that position.

PIERCE: Right. And we're seeing successes, success stories of APRNs who are in a lot of these specialty care areas too, like neonatal and critical care. You know, I've worked with some who were part of the staff in the critical care pulmonology. So, I mean, we are seeing success even in the, you know, the evidence is there that they are providing high-quality patient care, and it is so helpful in closing the gap. There's a shortage, having them there, a shortage of healthcare providers, which we'll talk about here in just a few minutes too. But what we see with this lack of recognition by our managed care organizations, you've probably heard them called MCOs, those third-party payers. They don't recognize, a lot of them do not acknowledge advanced practice nurses in their services like they acknowledge physicians. And so that's going to limit the billing opportunities and can even create financial difficulties for not just the provider, but also for healthcare facilities that employ these APRNs, you know, because they are not being paid as much as they would be for a physician. And then we're going to see variability in our insurance policies across all of our states and all of our providers, because you have some that require those supervisory agreements with physicians for nurses to even bill independently. Still, they can bill independently, but they still have to have a physician and be in an agreement with a physician. And so you see a lot of inconsistencies and that really complicates the reimbursement process. And because of these complications, I mean, think about the discouragement that some of these nurses, especially those in underserved areas where their services are really needed, think about the discouragement and just like, is this worth my time? I'm not being reimbursed. I'm not being paid like I should be. I'm not being paid what I should be being paid.

MCCORMICK: Right. Especially, you know, as that nurse practitioner, I work in a state where they have to have the physician coverage based on each sign off on their care. So if you work in a state where you want to practice, but you can't find someone to be your physician, then you're not able to practice to your full scope.

PIERCE: Yeah. So even though we're seeing these statistics, the evidence where nurses deliver high-quality, cost-effective care, there are some huge gaps in recognizing them, their services within that healthcare reimbursement system, which is because we have this physician-centric model, which is really hard. So what role do APRNs play, you know, and how do they influence changes in nursing reimbursement? So I was looking at that and obviously APRNs have played this significant role in trying to shape changes in nursing reimbursement by advocating for, we're still advocating in a lot of states to expand practice authority, to be able to directly receive reimbursement and really those policy reforms that recognize their contribution to healthcare. And we did see some major shifts. If you look at the Balanced Budget Act of 1997, it actually allowed nurse practitioners and clinical nurse specialists to be reimbursed directly by Medicare at 85% of the physician fee schedule. Now, I did do some research on this, and I found you can actually find the guidelines and regulations for CMS and we are still at the 85% of the physician fee schedule. Actually 80% to 85%. Now somewhere, let me look for this. I actually copied and pasted what they said on what I found on the guideline and I'm trying

to find where I put it because I was like, man, because it's not just 85%, it was actually lower.

MCCORMICK: And then while you're looking, what I'm thinking is, there are only.

PIERCE: Yeah, now I'm like I thought I had it where I could find it really, really fast, but. Go ahead.

MCCORMICK: I just keep thinking about how nurse practitioners are apparently only 85% as good according to this random, and I'm sure that there's a reason for it, but.

PIERCE: Yes, okay, found it. Yeah, okay. So in their regulations, and this is something that I was mentioning earlier that I was kind of like, you know, I understand what they're saying. So also on their CMS website, it says, "We consider the services of physician services. We consider physician services if a medical doctor or doctor of osteopathy furnish them." Okay, so in contrast, you're going to have physicians receiving full reimbursement at 100% of the Medicare physician fee schedule, okay?

But I will say a key exception to this is that with that 85% reimbursement rate, certified nurse midwives can receive 100% parity with physicians for their services under Medicare Part B, okay?

But it specifically says in their regulations that I looked at today, the day that we're recording, and it said in general, NPs and CNSs are paid for covered services at 80% of the lesser of the actual charge or 85% of what a physician is paid under the Medicare physician fee schedule. There is a separate payment policy for paying NP and CNS assistant surgery services as well. And I didn't look into those, but okay, so basically what we're seeing is 80% of the lesser of the actual charge or 85% of what is covered by the physician. You know, 1997, when that Balanced Budget Act came out. So that's been since 1997.

MCCORMICK: Yes, it's so long ago. I hate to think about how long ago that's actually been, but it's been so long ago.

PIERCE: Yes, you know, in 1989, the Omnibus Budget Reconciliation Act came out and it was also a pivotal moment for APRNs because it was the first time that nurse practitioners were allowed to receive limited direct reimbursement from Medicare. And so it was through that legislation that really laid the foundation for all these future expansions that we're seeing in APRN billing and reimbursement because for the first time, they were recognized for their ability to provide high-quality, cost-effective care, particularly in these underserved areas. But I mean, this initial step still had restrictions on the type of services that could be reimbursed and under what conditions they could be reimbursed. And then we went into the Balanced Budget Act that I just talked about in 1997 that basically our

reimbursement for APRNs is still under today. So, you know. We do have state Medicaid expansions and those have also helped with allowing nurse practitioners and nurse midwives and other APRNs to directly bill Medicaid for services provided to what they deem as eligible patients, not they as in APRNs, but they as in Medicaid. So, yes.

MCCORMICK: Right, which is good if your state did the Medicaid expansion. I'm currently in one of them.

PIERCE: Now, you know, we had the Affordable Care Act. I think that was, what, 2010? That really came in to try to reshape some reimbursement and what insurance looked like. And okay, so it was great in that it significantly expanded access to primary care and preventative services. But I mean, if you think about this, it created a greater demand on our healthcare system as a whole. So it created a greater demand for nurse-led care and really just reinforced the role that we need APRNs in the healthcare system. I mean, this act increased insurance coverage for millions of Americans. And so you're having millions of Americans that were not insured, that were not seeking out care, now coming into an already crowded healthcare system.

PIERCE: So that's what ACA really brought to the table and showed, we need APRNs, especially in these rural and underserved areas. So that was really good. But did you know that ACA also really encouraged value-based payment models?

MCCORMICK: No, tell me more about that.

PIERCE: Okay, so value-based payment models really prioritize patient outcomes and cost-effectiveness over that traditional model that you saw, which was like a fee-for-service system. And this was a huge shift directly benefiting nurses and APRNs who are really in the chronic disease management, patient-centered approach that aligns with the goals that we see with value-based payment models. So programs that we're seeing were like the Accountable Care Organization, the patient-centered medical homes. Those really created opportunities for APRNs to play this larger role in coordinating care, working to reduce hospital readmissions and really just improving overall patient care. So, I mean, that really opened the door for nurses to step into this holistic approach to care. You know, the ACA really just reinforced the importance of APRNs and helping to expand healthcare access, to grow our primary care areas and even our preventative services. Because, you know, we really lack in our preventative services and insurances aren't really necessarily paying for preventative services like they should be, you know, unfortunately.

MCCORMICK: I agree, our healthcare system is just one of like a reactionary. You're sick, now let's fix it instead of let's prevent you from getting sick to begin with.

PIERCE: Yes, absolutely. And if we could spend some time trying to keep people healthy, you know, it would take, I think, a pretty good burden off of the healthcare system that we see today.

MCCORMICK: And when you're speaking about the value-based system, I had a moment come back to me because I've been a nurse for 25 years, which is a long time.

PIERCE: Yeah, I would never know that looking at you.

MCCORMICK: Thank you. I was like, how did it go fast, so fast? But it just brought me back to those memories of how things in the hospital started to shift and okay, so now we're worried about the readmission. So we have certain bundles that we complete, certain care measures that we do for our patients before we send them home, certain criteria that they have to meet. You know, it's definitely, I'm not going to say it's like a textbook, everybody's the same, but I do see now that as we are working on that, that we have definitely changed at the bedside the things that we're doing and just our responsibilities for taking care of the patients to ensure that we would reduce those readmissions. And I also remember that just in the area that I'm from, and I live in a rural area, so we have healthcare deserts. My county probably doesn't have very many healthcare providers. But it was about that time I started to see nurse practitioners pop up and they would be in a very rural community. There would be one nurse practitioner who would see the patients under a physician's authority pretty much. And it really did start to make a difference. I noticed that, like you said, when people got healthcare insurance that we had lots more patients coming into the doctor and getting into the hospital.

PIERCE: Yes, yes, yes, absolutely. You know, talking about those readmission rates, because I have, I have seen where we have now shifted to readmission rates and then pay according to did they come back because, you know, and how many hours after they left, did they come back and insurance is making decisions to reimburse based on that when a lot of times we don't have control over what a patient does when they leave. So watching, I mean, are they going to follow our instructions? I have no idea, but you know. And so I just find it interesting how insurance is leading healthcare versus our providers who are making these decisions and leading healthcare. You know, why are we having to fight for the things that we need? It's just, it's been an interesting shift in the direction that healthcare is going. But I did want to talk about Medicare Part B reimbursement and the model that they used and how it really works for APRNs and how it differs. Because I know we talked about this a little bit when I was talking about the 80% and I was reading that stuff. But if you look at the CMS regulations and guidelines, it's going to include, they include APRNs, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and then of course the certified nurse midwives. I think I got them all. And they do have the ability to bill Medicare directly for services that they provide to their beneficiaries. But like I said, you know, I was talking about the 80 to 85% of that physician fee schedule, meaning that the same service that the APRN provides, the same service a

physician is going to receive 100% of that reimbursement and that APRN is going to receive the reduced rates. And unfortunately, this policy, when I was looking at it, really reflects the longstanding payment structures that differentiate reimbursement between physicians and non-physician providers, even though we know and we have the evidence to show that APRNs are delivering high-quality, cost-effective care. So again, it's that physician-centric model. I mean, that's exactly what this is, is a physician-centric model. Now, as I said earlier, I could not figure out why certified nurse midwives receive more. You know, when I said earlier that they receive 100% parity with physicians, and it could have just been I was looking in the wrong place. I'm sure that this probably goes back to advocacy or something, but midwives are reimbursed at the same rate as physicians when providing maternity care, gynecological services, and you know, healthcare services that fall under that. What I did find is that it was stated that the decision to grant the certified nurse midwives full reimbursement was based on evidence demonstrating their effectiveness in improving maternal and infant health outcomes while reducing overall healthcare costs. So that leads me to the question. You know where I'm going with this question. What question am I about to ask?

MCCORMICK: Absolutely. Why are the rest of them not the same when they save so much money?

PIERCE: Right, when we have evidence demonstrating the other, the effectiveness of the other APRNs. Why, oh why is that? So I don't know who took that in to, I don't know how that got taken in and that was really what I found on that. So Medicare's recognition of APRNs' ability to bill directly has really been a huge step in solidifying the role of APRNs as independent healthcare providers. Even though we see that it is still physician-centric led, it has helped with them being identified as independent healthcare providers. And, you know, we're still seeing advocacy to push legislation changes that would increase APRNs to that 100% reimbursement rate with CMS because the argument there is that if we have equitable pay, that would help address provider shortages, expand access to care, and really just recognize the full value that APRNs bring to healthcare.

MCCORMICK: You know, I'm excited to think about the potential that it can be changed to recognize the value that they do bring.

PIERCE: Yes, absolutely. Okay, so, you know, looking at reimbursement policies and how they influence nursing autonomy and full practice authority, we know that when reimbursement structures recognize APRNs as primary care providers and allow for that equitable pay rate, then it's going to really support greater autonomy because we're going to see reduced financial and administrative barriers for us to practice independently. Versus those restrictive reimbursement policies that require physician oversight, that offer lower reimbursement rates, they really limit the APRN's ability to fully exercise their training and their expertise. If they're in practice for themselves, they still have to be able to cover the same things, the same that a physician would have to cover if they were in

independent practice. So, you know, when you have full practice authority, you have APRNs evaluating patients, diagnosing conditions, prescribing medications, and managing treatment plans without a physician there. You know, they can practice on their own. So, if a reimbursement policy is going to favor that physician-led care, requiring that they collaborate with a physician for billing or reimbursing APRNs, obviously at this lower rate, then it's going to undermine the ability to make independent decisions and practices, where you are, where you have basically provider deserts. It's going to limit that APRN's ability to have a clinic there.

MCCORMICK: Absolutely. And then too, just if the public perception, if I found out that my nurse practitioner is only 85% as good according to the reimbursement, am I making those decisions? And so that makes me think about that too. We need the nurse practitioners, especially in the provider deserts, but we have patients who don't understand the full scope and authority of what nurse practitioners do still. And so we need the public sentiment to recognize and understand, especially in when they're managing populations that have a lot of chronic conditions. We need them to put their trust so that they'll listen and let us educate them. They're able to make their own decisions, of course, but trust what the nurse practitioners are saying and their ability to manage.

PIERCE: Right, and you know, as nurses, we focus on that holistic preventative approach versus, you know, what a lot of our physicians do. I know it's becoming more and more popular to not just be diagnosis-centric in our care, but the value-based payment model that we are also seeing, you know, that really encourages the team-based, outcome-driven care approach. And that really aligns well with how nurses who are now APRNs, how we practice, which really supports our role as primary and specialty care providers. So I felt really encouraged when I was reading about the value-based payment model. But again, equitable reimbursement policies are so needed. They really legitimize APRNs as essential providers in our healthcare system so that they can practice to their full extent.

PIERCE: So I want to talk a little about the COVID-19 pandemic and how it changed the telehealth reimbursement and kind of that telehealth landscape. Cause I think that's also important to our reimbursement as nurses. But you know, COVID-19 brought significant changes in the telehealth arena, especially in how we reimbursed for it for nurses and even APRNs. So, you know, we had federal and state policies that adapted to expand this virtual care. You know, prior to the pandemic, telehealth reimbursement was really, really limited. And there were so many restrictions on where services could be provided and who could bill for them and how much providers were actually reimbursed. And then COVID-19 came, and people were encouraged to stay at home. And so that's where we really saw this expansion of telehealth in response to that public health emergency that was declared. So we saw a lot of key policy changes that were just temporarily increased, temporarily changed, and it really helped with giving the nurse more ability to deliver and also to be paid for the care they deliver through telehealth. One of the most significant

changes that we saw was Medicare's expansion. And that allowed APRNs to provide and bill for telehealth services in like a much bigger scope. Now, previously, Medicare had really strict rules requiring patients to be located like in rural areas. They're probably in your area in order to receive telehealth services in a clinical setting. And the pandemic really moved us to lift these geographic restrictions, which allowed patients to receive care in a wider range of virtual services. And additionally, payment go ahead.

MCCORMICK: I just want to say what a blessing it was too, because prior to the pandemic I remember having to go see a specialist and the closest one for me is two hours and I was eight, and I luckily had the transportation and the ability to get there. But I think about all the patients that I've taken care of over the years who don't have that luxury of being able to have the gas money and the ability to drive two hours to see a provider.

PIERCE: Yeah, absolutely. And something that was very helpful was the payment parity policies that we saw with insurance companies. They temporarily allowed for telehealth visits to be reimbursed at the same rate as in-person visits. And so that really made telehealth a more financially viable option for nurses and other providers and really encouraged the widespread adoption that we saw and still kind of see today of telehealth. Medicaid programs and private insurances, they really started to follow suit, and they expanded telehealth coverage and reimbursement for APRNs to include not just mental health, but chronic disease management and primary care. So that was very helpful. Something else that we saw was this major shift in state licensure and supervision requirements, particularly in states where an APRN previously had to have physician oversight in order to, you know, provide and bill for telehealth services. So a lot of states were granted, it was temporarily granting full practice authority for APRNs, but during that temporary granting of FPA, it allowed them to independently deliver virtual care and bill for their services without a physician collaborator. So that was helpful.

MCCORMICK: Yeah, it was fantastic. I remember personally back, I'm just going to say personally back in COVID, we were all like, stay home, don't go to the doctor. Because if you don't have COVID, then forget it. And so, so many people with chronic conditions just went without going to the doctor. So having that ability and having that reimbursement was, it was just such a great thing.

PIERCE: Absolutely. Now, unfortunately, a lot of these reimbursement expansions were temporary and, you know, were removed after we came out of the declared public emergency. But what we did see from the pandemic through this was just how effective telehealth can be in providing access to care, in reducing healthcare costs, and really just maintaining that continuity of care for our vulnerable patient populations. And today, as a result, well, yes, some of these have been rolled back to, I guess, would we call it back to normal? A lot of policymakers and healthcare organizations are advocating for making telehealth reimbursement for APRNs permanent, really trying to ensure that continued flexibility and financial support for nurse-led care. A lot of the changes are still in place

today, which has led to improving access to nurse-led healthcare, telehealth care. But we have seen some roll backs. But I think the data is there to support, you know, no, we need this. Our healthcare system does need this. So, you know, that's, I hate to see, I hate to have seen some of this roll back.

MCCORMICK: I feel like it's just going backwards, away from something that was actually working.

PIERCE: Yes, for sure. We have continued ongoing efforts working towards achieving equal reimbursement. I don't know if we'll ever get there, but we are still fighting to get there. So we have nurse-led organizations like the American Association of Nurse Practitioners and the American Nurses Association that we know are really pushing for the Medicare parity for APRNs to be at that 100% of the physician rates. That's where we should be. And then independent billing rights in all states. But you know, we really need the ability to autonomously practice in all states as well to go along with that independent billing.

MCCORMICK: I agree. And then to me, it's so confusing from state to state what nurse practitioners are allowed to do. And the rules are so specific in each state that to me, it just confuses the whole system even more. I wish there was, which there'll probably never be, but I wish there was a way to make it more equitable across what is practiced from one state to the other.

PIERCE: Yes, absolutely. It's really confusing. It's kind of like our license. We have the state individual license for nursing. We have the compact state. I couldn't remember the word compact, which I have a compact. I couldn't remember the word compact. But then we have the compact, but you still fall under the state that you're practicing in. And I actually had a friend who moved here, had a compact state, moved to the state that I'm in now. And she was like, she was in the military. And you would think that she could practice under her compact state, right? I mean, yes, but no. They came to her, and they said, you live here now, you have to have a license through us. And you know, and the argument is, but I have a compact license. I don't understand. Because when I got my license early on, I had a compact state and it was, I remember it was Arkansas, and I had gotten married and I moved to North Carolina and I practiced under my, I mean, under my compact state license of Arkansas at the time. So this was the first time that I had heard that, and she had to go, she had to jump through a bunch of hoops to even get her license for this particular state, even though she already had a compact state license.

MCCORMICK: It's crazy because travel nurses would travel and practice with that same compact license.

PIERCE: So, you know, it's not even just billing and reimbursement that is confusing as a nurse, but also when we look at our license and where we can practice and the different

kinds and how our scopes are different in different states, you know, it is very hard to balance all of that and to know all of that.

MCCORMICK: Going back to the idea of telehealth, which is a fantastic thing, it's just another consideration. You can do telehealth, but it has to be with a patient that's within your state. And I live on the border of the state, and literally I'm like, okay, if there's an emergency, there's a hospital that might be closer, but I got to go to the one in my state for insurance.

PIERCE: Right, yes. And that's really hard too, but when you were talking about that, I was just thinking about, you know, those people that have to drive to a different state in order, if you were to do telehealth, you know, are they going to have to drive 10 minutes up the road to be across the state line in order for you to see them? So, yeah, there's just so many pieces to this, financial pieces to this, you know, and something else that I've seen them pushing for as well is more or maybe more is the right word or higher is the right word, reimbursement for nursing home and home health RNs. And I did not look more into that information. It'd be interesting for me to go back and look into that. But I was like, huh, you know, it makes sense.

MCCORMICK: It does. I mean, and we need that reimbursement because we are already so short on the number of nurses, RNs and LPNs who are in the nursing homes and there's no benefit of hiring extra people to provide better care as far as the organization is concerned unless they're being reimbursed for them actually providing the care. So it's such a struggle.

PIERCE: Yes. Now, last year, I know we started off this episode talking about the Commission for Nursing Reimbursement. So that is also something that is another organization that is advocating for equal reimbursement for APRNs. And I wanted to just kind of see what they were about. So I went to their website. And directly from their website, it says that their purpose was that they were launched in response to nationwide concerns about nursing staffing shortages. It will work to change the way that Medicare reimburses healthcare systems for the valuable care that nurses provide. So I found that interesting as well to see just what all these different organizations, and I'm not pushing an organization on anybody, it's just knowing what is happening within our profession and who is doing it and where we're headed. So I did find that interesting to see that they were focused on CMS and how CMS reimburses. Because I do think my personal opinion on CMS is that I feel like they provide kind of the groundwork, the framework for what a lot of our other insurances are doing. So maybe if we have change with them, CMS.

MCCORMICK: Yes, they're definitely the rule-makers.

PIERCE: Then we can have change within our private insurance companies. I don't know if it could happen or if it's going to go that way, but that's just something that I've seen in my

time in practice. So I don't know what your thoughts are on CMS and the framework they provide.

MCCORMICK: I mean, there's good and bad of everything. And I definitely see that they are the leader. So they, you know, just as working as a nurse at the bedside, some of the things that they said, you know, that before the patient goes home with X diagnosis, we expect to do X, X, X. And so, which isn't a terrible thing to have that standard and make sure that people get some of the care, but they definitely are the leader and the other ones follow. And so as that leader, they really need to be innovative, especially in a country where our healthcare system needs work. And in this country where our citizens are just getting older and older, our aging population is growing. And like I said earlier, I've been a nurse for 25 years and the patients I used to get on a med surg or a step down unit were not the same as what we're getting now. They're so much sicker now. So as our country adapts, since these rules made in 1997 and even 2010 have been made, it's not the same hospital that it used to be.

PIERCE: Yes, and the knowledge that we need and the work that we do is so different now. Yes, even critical care is where I've spent the majority of my time and even there, so many patients are so much sicker than before. Yes, I absolutely agree. So as we get ready to end this episode, one of the things that I wanted to just kind of talk about is where do we predict the future of nursing reimbursement going? And that's really hard to say. So I just wanted to kind of just touch on this and talk about where we think this might be going based on what we're seeing. So there's three things that I saw that really stood out to me. And that was greater Medicare parity for APRNs. You know, that full 100% reimbursement is really what is being pushed for. I hope eventually we will get there because we do have that evidence, and the evidence continues to show that all of our APRNs provide high quality, cost effective care. So hopefully policymakers will make those adjustments to that reimbursement model to reflect the value, to be more equitable to the care that we're showing. You know, it worked for the certified nurse midwives. I don't know how it worked, but we have the data for the rest of our APRNs too. So that should be where we are headed in the future. And if you hear any noises, it's because I have my hands, I'm very passionate about this and I've been hitting my desk, like we should be there too at some point in the future. So, yeah.

MCCORMICK: Absolutely, and I think a lot of that is the need for us as nurses and then the nurse practitioners as well to advocate. That advocacy is so important. They need to hear our voices, and they need to realize too that as short as we are with nurses and nurse practitioners, physicians too in this country, that if you're doing things to discourage nurse practitioners to be nurse practitioners, then you're really going to worsen the problem. You know, if you're having to, you know, that 18-year-old student who's trying to determine the way to go with their career, you really need to show them something that indicates that they would be of value to pick that profession.

PIERCE: Absolutely. Now, talking about telehealth services and the reimbursement for telehealth services, I don't know if you saw this, but in March of 2025, legislation was enacted for Medicare. They authorized an extension of a lot of their telehealth provisions through September 30th, 2025. You know, March, I think it was March 15th, 2025, through September, the end of September 2025. And that extension really allowed Medicare beneficiaries so that they can continue to receive telehealth services from their homes without those geographical restrictions that they had before. So I do think that in the future, we're going to see some continued growth and changes in the telehealth world, maybe moving towards a more permanent expansion of telehealth reimbursement. You know, just following suit with Medicare. They obviously saw benefit in this in order for them to expand it. Why else would they expand it? So hopefully they will make this a permanent expansion, and then other insurances will hopefully follow suit. Maybe. Yes.

MCCORMICK: I know, for my own self, my personal health insurance, we still have the Teladoc services for just those primary, you know, quick little illnesses. I have the sniffles, I need to call and talk to somebody. And I'm going to tell you that has prevented me from clogging up my own doctor's office for things that you need a medicine for, but you don't necessarily need to go to the doctor and infect other people. So it really helps.

PIERCE: The other thing that I think we're going to see is, you know, we're seeing the healthcare system as a whole really shift away from that fee-for-service model and going more towards, we talked about earlier, the value-based reimbursement. And because that's going to prioritize patient outcomes, it's going to prioritize quality of care and really cost-effectiveness of the care that they receive. But it's going to give APRNs more of an opportunity to be able to see an increase in their reimbursement opportunities, especially those APRNs who emphasize the preventative care and the chronic disease management. They're very well positioned to thrive in a value-based reimbursement model because they're going to be able to participate in programs like the accountable care organization and patient-centered medical homes. So I do think that that will open the door for more reimbursement opportunities. Again, these are just looking at where we are and the scope of what's been happening. These are just, I'm not saying that this is going to happen, but this does seem to be the trajectory that we're flowing into.

MCCORMICK: I agree, because of some of these, you know, the chronic conditions, the people who have been doing this since that change went, I think it was 2010, since those changes, you know, the research indicates that it's working. And so I think as we see further time periods pass where you see the difference, it definitely looks to be headed that way.

PIERCE: Yes, absolutely. Another question that I have seen come around is how can nurses stay informed and involved in health policy and reimbursement advocacy? And really, you know, staying involved in some of these nursing advocacy groups, find the one that aligns with, you know, where your beliefs are as far as nursing reimbursement. And,

you know, they support a lot of other things too. So really just doing your research to find the one that aligns with you and your values, also attending conferences and nursing board meetings. They do have, I know they had it in the state of Alabama when I lived there, but they had, it's a day for nurses to come to the Capitol. Do you all still have that in Alabama?

MCCORMICK: Yeah, we sure do. We just had it a few weeks ago.

PIERCE: Yes, and then they do have a federal one as well where nurses, I don't know when that is, but I have seen nurses going to the White House. So yeah, I want to do that. So really, it's that local and national lobbying efforts are there, attending board meetings, being really active with your board. All of those are places where you can continue to see where we are in health policy and reimbursement advocacy.

MCCORMICK: Absolutely. And then to write to your legislators. That's something that, you know, when there's something that really stands out, especially right now in Alabama, they're looking at passing some different nurse practitioner level bills and this back off topic. Alabama is the only state in the country where a nurse practitioner can't inject Botox. I think that's interesting. Yes. Can you believe that? But you got to have the doctor do it. We are having those. I think, you know, we underestimate the value of letting your opinion be known that I'm a nurse. I live in your district. This is how I feel about this topic and using your nursing voice to really advocate for your own profession with the people who are in office.

PIERCE: Yes, absolutely. I agree. Well, that's really all the information that I have to share today. It was a lot. It was a lot to cover. But is there anything that, you know, I missed, or you want to add to our discussion?

MCCORMICK: No, I'm just excited to see where things are going in healthcare. I'm excited to see that things, they are changing. And I just believe that because of the value-based changes and the things that we've talked about today we have potential to see even more changes that are really going to value the nurse and the nurse practitioner, certified nurse midwife, and so on, as the professionals that we are.

PIERCE: Yeah, and what we bring to the table, so important. Well, I just love this topic that we covered today and just being able to go backwards and to learn about our history and where nursing started and how we got to where we are today. But that really wraps up our discussion on nursing reimbursement. And I think it's going to be interesting to see where this actually goes in the future. Maybe 10 years from now, we're doing another podcast just being like, this is where we were then, and this is where we are now. Thank you.

MCCORMICK: Yeah, it definitely would be. Thank you, Robin, for joining me and contributing to this topic and this discussion today.

MCCORMICK: You're welcome. I enjoyed it.

PIERCE: Yes, to our listeners, I encourage you to explore many of the courses that we have available on EliteLearning.com to help you continue to grow in your careers and earn CEs.