Health Occupations Regulation and Health Care Reform

nnesota Department of Health
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EXECUTIVE SUMMARY

The report on occupational regulation and health care reform was prepared to address concerns about how occupational regulation interfaces with health reform. This report reviews the current legislative mandate on credentialing of health-related occupations, the effectiveness of current regulations for health-related occupations, and the impact of occupational regulation on access to care, quality of care and cost of care. Key findings regarding the impact of regulation on quality, cost and access to health care are as follows:

- State credentialing of occupations provides a necessary mechanism for consumer protection through quality assurance functions such as establishing minimum standards for credentialing, establishing standards for renewal of credentials, establishing minimum standards of practice, and processing complaints against practitioners.

- The Office of Mental Health Practice provides protection to the public from unlicensed mental health practitioners. There is no similar mechanism for responding to consumer complaints about other unregulated health care providers.

- Occupational regulation is entirely fee supported as required by Minnesota Statutes, §214.06. This means that all occupational regulation costs are ultimately paid for by consumer payments for health care services.

- The ongoing costs of regulating occupations can fluctuate greatly in response to changes in credentialing standards and the level of disciplinary activities.

- Based upon the available financial information, it is not possible to determine the total cost of occupational regulation in Minnesota over the past five years.

- Practice acts do not explicitly regulate consumer access to services provided by an occupation, however, changing the standards of a regulated occupation may affect the supply of practitioners and consumer access to health care services.

- Credentialing systems provide valuable services in addition to the expected consumer protection services. These services include the identification of qualified practitioners to third party payers and the creation of a database which facilitates the monitoring of practitioner geographic distribution and specialty, assisting public health agencies in planning and consumers with access to necessary health care services.

- Current outcome measures provide limited information for accurately determining the impact of occupational regulation on health care reform goals dealing with the quality, cost and access to delivered health care services.

- The criteria of Chapter 214 for determining occupational regulation are difficult to apply, involving complex relationships among elements pertaining to risk of harm and cost-effectiveness. When regulation is imposed, there are no apparent policies or guidelines for determining the most appropriate administrative structure.

- Credentialing agencies encounter conflict between their policy and regulatory functions, particularly in the setting of occupational standards for entry and practice.

CONCLUSIONS AND RECOMMENDATIONS

The report concludes that further information gathering and analysis by the Minnesota Department of Health, (MDH), and health-related licensing board staff is needed to assess legislative credentialing policies, regulatory trends and factors currently important to the health care markets. The Commissioner has formulated several recommendations to follow up on the findings noted above. However, implementation of the recommendations may be compromised by anticipated reductions this biennium in state and federal funding for occupational analysis, health planning and data collection activities. As a result, MDH and the health-related licensing boards may need to prioritize and postpone some of the following recommended activities:

- The legislature should declare a moratorium on further regulation of allied health occupations. During the period of the moratorium MDH and the health-related licensing boards shall discuss and develop recommendations regarding issues of health care quality, cost, access and government administration.

- MDH and the health-related licensing boards shall develop and submit legislation seeking authority for and funding to provide for the receipt, compiling, referral and investigation of complaints against unregulated health and human service providers.

- MDH and the health-related licensing boards shall develop and recommend a uniform procedure for responding to and recording consumer inquiries to credentialing agencies.

- MDH and the health-related licensing boards shall review and analyze health care reform information on provider utilization (especially the allied health occupations), reimbursement patterns, and the cost of services to assess the impact of health care reform on occupational regulation.

- MDH and the health-related licensing boards shall develop and submit legislation defining and establishing appropriate performance measures, such as outcome measures, output measures, efficiency measures and cost-effectiveness measures so that consistent data related to effectiveness of regulation can be reported by all entities responsible for occupational regulation.

- MDH and the health-related licensing boards shall recommend to the legislature whether the criteria for determining the need for occupational regulation set forth in Minnesota Statutes, §214.001 should be revised for future evaluation of the need to regulate allied health occupations.

HEALTH OCCUPATIONS REGULATION AND HEALTH CARE REFORM

I. INTRODUCTION

This study originates from the Minnesota Department of Health's, (Department), desire to reassess its role in the evaluation of health-related occupations for credentialing by the state. Minnesota Statutes, §214.001, subdivision 1 provides a legislative directive to limit occupational regulation to those situations where it is required for the safety and well being of the citizens of the state. Superimposed on the existing legislative policy, which the Department has interpreted as limiting occupational regulation, is the new legislative policy for the health care market based upon health care reform goals. Would the goals of cost containment, access to services and quality assurance stimulate additional occupational regulation? How should MDH respond to occupational groups seeking regulatory recognition as providers within a reformed health care system? To address these issues, Department staff determined that a review of the Department's role in occupational credentialing was warranted.

Preparation of this report involved review of various occupational practice acts in Minnesota statutes and rules, review of the statutorily required biennial reports from the health-related boards to the legislature, a review of literature, interviews of individuals within the Department involved in health reform efforts, interviews with representatives of health plans and purchasers of health plans, and interviews with legislative staff. After beginning research, staff determined that it was appropriate to involve the health-related licensing boards.

Prior to finalizing this report, a draft was submitted to the Directors of the health-related licensing boards. The Directors reviewed this report and submitted a letter to Acting Commissioner Anne M. Barry containing their reactions and comments. This correspondence has been included in the report. Some factual corrections were made in the report based upon their suggestions to clarify certain findings and discussions. Other findings and discussions remain as originally stated. Distinct differences in viewpoint and opinion between the Department and the health-related licensing board Directors appear to arise from the different roles that the Department and the boards have in protecting the public health. The mission of the health-related licensing boards is public protection through occupational regulation whereas the Department's mission includes consideration of cost and access issues in addition to public protection. A paragraph was added to the discussion in Administration - Finding 1a, page 20 to reflect this distinction. The Department respectfully acknowledges the differences in opinion, but maintains its position on the cost and access findings in the report.

The Department also looks forward to continuing the discussions with licensing board Directors begun during the writing of this report. The ability to implement the recommendations may be compromised by budget decisions to be made in the 1996-1997 biennium. Accomplishing the activities recommended herein will depend on the Legislature's awareness, responsiveness and commitment to occupational regulation issues. The Department acknowledges the discrepancy between the need to have the Department evaluate and determine appropriate regulation of allied health occupations and the need to reduce state expenditures in times of limited resources.

State of Minnesota
Health Licensing Boards

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March 23, 1995

Anne M. Barry
Acting Commissioner
Minnesota Department of Health
717 Delaware Street SE
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Dear Commissioner Barry:

On behalf of the health licensing boards, I want to thank you for giving us the opportunity to review a draft of your forthcoming report, "Health Occupations Regulation and Health Care Reform." We support cooperative efforts between the Health Department and the boards, and we are encouraged that communication is occurring on matters of mutual concern.

We are pleased to see that you are raising a number of important questions that have not received adequate attention in the past, and we support many of the findings and recommendations presented in your report. One recommendation we endorse is to develop "criteria for determining the most appropriate organizational structure for administration of any new occupational groups or established groups seeking a change in administrative structure." The boards are concerned that groups seeking credentialing may not be fully aware of the regulatory and organizational options, and we are already reviewing ways of providing this kind of information. We would welcome your participation in this process.

We are also supportive of your recommendations that the Minnesota Department of Health and the health licensing boards address issues of common interest, such as government administration. Because both the Department and the boards have responsibility for health occupation regulation, we think it would be very useful for us to work together to develop some mutually agreeable ways of improving our services.

Some of your findings and recommendations, however, we find to be problematic. Particularly troublesome is your statement, "Current credentialing systems appear to primarily benefit the occupation rather than the consumer. Licensure limits practice of a certain occupation to those meeting requirements in the practice act, reducing the pool of providers and theoretically leveraging the income of licensed practitioners." In our view, this statement assumes an either-or situation where benefits to the public and to practitioners are mutually exclusive. We would argue that our primary purpose is protection of the public, and to the extent that we succeed, we are also serving the interests of the regulated professions.

We are puzzled by the intent of your statement, "Regulation, especially in the most restrictive form of licensure, limits the pool of practitioners to those with prerequisite education and or

qualification," followed by a number of assertions that imply that such requirements have adverse consequences. Does the department believe that standards on "prerequisite education and or qualifications" should be abandoned? We are concerned that the report does not acknowledge that such standards are designed to protect the public. Elsewhere the report emphasizes the importance of taking disciplinary action for "incompetent or poor quality practice." What would be the basis for such disciplinary action if there were no standards on education and qualifications?

The report does not make clear that the role of occupational regulation is to regulate the behavior of individuals; in our view, it is not the role of occupational regulation to address systemic issues such as health care costs, access, or the problems faced by disadvantaged groups in our society. We realize that because the Department has broader responsibilities, it is within your purview to address such issues. We believe you should be cautious, however, about making recommendations that may imply a broader role than is appropriate for the boards.

We believe that your report places undue emphasis on the cost of health occupational regulation. Although you state that "it is not possible to determine the total cost of occupational regulation in Minnesota," you suggest elsewhere that the costs of regulation are high and that it may reduce access to health care services. You cite as an example that after hearing instrument dispensers were required to take an examination, the number of dispensers dropped by 45%. We do not understand what point you are trying to make. Are you suggesting that the public interest was not served by eliminating dispensers who failed the examination? Are you suggesting that the cost of developing and administering the examination was too high to justify the results? We would argue that whatever measures you use, it would be difficult to show that health occupational regulation is not cost effective.

There are a number of specific statements made in the report that we believe are inaccurate, misleading, unsupported, or out-of-date. We have already discussed some of the most problematic with Tom Hiendlmayr. We will not attempt here to address every point we would like to make. As indicated earlier, we are pleased that lines of communication have been opened and we would like to continue providing assistance as appropriate. We believe that it would in your interest as well as ours if in the future you could ask for our participation as early as possible in the process.

We would welcome the opportunity to continue a dialogue with you on the issues you have raised, as we are convinced that we can most effectively achieve our common objectives by working together.

Sincerely,

H. Leonard Boche, Chair
Executive Directors Forum

cc: Tom Hiendlmayr

III. BACKGROUND

A. OCCUPATIONAL REGULATION POLICY

The legislative policy for occupational regulation is contained in Minnesota Statutes, Chapter 214. According to Chapter 214, occupational regulation is to be limited to situations where it is necessary to protect the public safety and well being. In determining whether an occupation shall be regulated, the following factors are to be considered: a) whether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of the public and whether the potential for harm is recognizable and not remote; b) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability; c) whether the public is effectively protected by other means; and d) whether the overall cost effectiveness and economic impact is positive.[1] Theoretically, any unregulated occupation requesting regulation by the state is to be evaluated using the above factors to determine whether regulation is warranted.

Once the determination is made to regulate an occupation, regulation may include a variety of measures, such as: a) the creation or extension of common law or statutory causes of civil action or the creation or extension of criminal prohibitions; b) the imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts; c) registration (practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications); or d) licensing (practitioners must receive recognition by the state of having met predetermined qualifications in order to practice).[2] A combination of any one or more of these measures may be employed to regulate a particular occupation, using the least restrictive means of regulation.

The Commissioner of Health has the authority to review human services occupations and determine whether they should be credentialed.[3] As directed by statute, the Commissioner has established procedures for identifying human services occupations "not now credentialed" by the state.[4] The procedure for evaluating the need to regulate these occupations is described in Minnesota Rules, chapter 4695. The rules provide more specific guidelines for application of the statutory criteria for determining regulation.[5] Traditionally,

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[1]Minnesota Statutes, §214.001, subdivision 2

[2]Minnesota Statutes, §214.001, subdivision 3.

[3]Minnesota Statutes, 214.13, subdivision 1.

[4]ibid.

[5]Minnesota Rules, part 4695.0800.

the potential for harm to the public has been the factor most emphasized in the occupational review by the Department.

Although the Commissioner has been given the authority to review requests from human services occupations for credentialing, funding by the legislature for this activity has been intermittent. Initially the legislature provided funds for Commissioner review with the assistance of a Human Services Occupations Advisory Committee (HSOAC) for fiscal years 1976 through 1982. Funding for the review process was withdrawn for fiscal years 1982 through 1984. The credentialing review activity received funding again for fiscal years 1985 through 1990. Funding was once again withdrawn for fiscal years 1991 and 1992. In 1993 legislation the statutory provision establishing the Human Services Occupations Advisory Council was abolished, leaving the Commissioner to make credentialing determinations based upon staff studies. Funding for occupational review was appropriated in 1993. Then Commissioner of Health, Marlene E. Marschall requested the legislature declare a moratorium on further regulation of allied health occupations. Commissioner O'Brien reaffirmed this as a position of the Department in her tenure. The Department opposed regulatory efforts by acupuncturists and dietitians and nutritionists in 1994. Currently there are a number of occupations seeking state regulation or changes in their regulatory scheme. (See Tables 1 through 3 in Appendix A)

The review of requests for credentialing from occupations remains suspended pending the outcome of this study. Occupational groups show a strong tendency to view licensure as the optimal form of state regulation. There is little general knowledge or understanding of other, less restrictive modes of occupational regulation. (See Table 4 in Appendix B for distinctions among occupational regulation systems.) As a result, the onerousness of licensure is given little consideration in view of actual threat of harm and the need for public protection.

B. HEALTH CARE REFORM GOALS

In 1992, the Minnesota legislature enacted the HealthRight Act (now known as MinnesotaCare) as a measure to contain health care costs, increase access to care for the uninsured and improve the quality of care.[6] Through this legislation, the legislature intended to limit the growth of health care expenditures, reform insurance practices and finance a plan to provide access to affordable health care to Minnesota residents, beginning with those who were uninsured or underinsured. Additional legislation in 1993 and 1994 further expanded the goals of health care reform to "assure quality, affordable, and accessible health care for all Minnesotans".[7]

A variety of mechanisms have been initiated to attain the stated goals of the legislature. Integrated Service Networks, (ISNs), will be established in the near future, with Community Integrated Service Networks, (CISNs), currently beginning operation. Finally,

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[6]1992 Minnesota Laws, Chapter 549, Article 1, Section 1.

[7]1994 Minnesota Laws, Chapter 625, Article 1, Section 1.

Standard Health Coverage, (formerly known as the Universal Standard Benefit Set), is being developed. These measures will impact the utilization of health care providers, but do not specifically identify the roles of the various health-related occupations or of occupational regulation by the state.

ISNs will provide health care services to consumers through a managed care system. The legislation allows the Commissioner to promulgate rules to allow ISNs to develop their own credentialing criteria for providers in their system.[8] ISNs are required to file action plans in which they detail how they determine participating providers.[9] The action plan must also include information on the numbers of physicians, non-physician providers and allied health providers.[10] Information is also required on the actual utilization of mid-level practitioners and allied health professionals.[11]

Standard Health Coverage proposals attempt to establish a core of standard benefits providing access to appropriate and necessary health care services. The standard benefits set will serve as a benchmark for consumer comparison of products offered by the various health plans. In addition to other benefit packages, all health plan companies would be required to offer a set of standard benefits by July 1, 1997.[12] The Standard Health Coverage legislation aims at developing a definition of appropriate and necessary services and the standardization of exclusion lists. Standard Health Coverage proposals are not specific regarding providers of covered services.

Although occupational regulation is not a prominent feature of health care reform efforts, several concerns are raised regarding the role of occupational regulation. New occupational groups continue to request state review and credentialing, especially in the wake of the expanded provider network provision. The health care reform effort raises questions regarding the economic impact of regulation on the health care delivery system. In theory, occupational credentialing results in increased prices in services to consumers at a time when cost containment is being emphasized. Finally, there are concerns regarding the role of occupational regulation given the new health care market. Health plan companies have their own criteria for credentialing providers within their system. These factors provide impetus to the need to study the relationship between occupational regulation and health care reform efforts.

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[8]Minnesota Statutes, §62N.05, subdivision 2(16).

[9]Minnesota Statutes, §62Q.07, subdivision 2.

[10]ibid.

[11]ibid.

[12]Minnesota Statutes, §62Q.21.

IV. ISSUE ANALYSIS

Preliminary discussion within the Department yielded two primary questions for study. This report uses these questions as the basis for discussion of occupational regulation:

1) Does occupational regulation have discernable, positive effects on the quality, cost and access to delivered health care services? and

2) Do outcomes of occupational regulation indicate a need to revise the legislative policy concerning occupational regulation articulated in M.S. §214.001?

Quality, cost and access factors will be examined in detail in attempting to answer the questions posed in this report. There are some limitations on the information discussed due to availability of data. Where data is limited, this report mentions the need for and makes suggestions for additional study.

A. QUALITY

While the health care reform legislation discusses quality as one of its goals, there is no definition of "quality" contained in the statutes. For purposes of this discussion paper, "quality" will be defined as the expected degree of technical care and interpersonal skill that results in desired health outcomes.

QUALITY - FINDING 1

State credentialing performs such quality assurance functions as establishing minimum standards for credentialing, establishing standards for renewal of credentials, establishing minimum standards of practice, and processing complaints against practitioners.

Currently in Minnesota law there are practice acts for audiologists, chiropractors, dentists, dental hygienists, dental assistants, hearing instrument dispensers, marriage and family therapists, nursing home administrators, nurses, optometrists, physicians, physician assistants, physical therapists, podiatrists, psychologists, social workers and speech pathologists. These practice acts include health-related occupations which are licensed, certified, and registered. (See Table 5 in Appendix B) Practice acts contain provisions addressing the scope of practice, minimum entry requirements, continuing education, disciplinary measures, and, in some instances, business practices such as advertising, fee splitting and record keeping.

A common assumption is that occupational regulation assures the quality of services provided by regulated practitioners by requiring minimum qualifications for credentialing, assuring continuing competence through continuing education requirements and establishing standards of practice, violation of which leads to discipline. A review of the practice acts and their application reveals a different situation.

QUALITY - FINDING 1a

Current credentialing systems establish minimum requirements for the training and education of practitioners.

Practice acts are viewed as the primary means for assuring the quality of services provided by regulated practitioners. These acts contain provisions requiring that applicants meet minimum entry requirements to obtain credentialing and that regulated practitioners meet continuing education requirements to maintain credentialed status. Despite the accepted premise that education and training requirements assure the quality of services provided by regulated practitioners, researchers question the validity of this assumption.

All practice acts contain minimum requirements for credentialing. These minimum requirements act as a barrier or screen to entry into the occupation and may include education, training, examination, experience or a combination of the above. In addition to basic entry requirements for those new to the occupation, most occupational groups have provisions to allow practitioners from other states to become credentialed in Minnesota. Endorsement or reciprocity provisions usually require that an applicant hold a valid and current credential in a jurisdiction with entry requirements equivalent to those of Minnesota. Newly regulated occupations may also contain a clause in their practice act which allows current practitioners to become credentialed without meeting the entry requirements for a limited period of time, after which applicants must meet the usual entry requirements. In these ways credentialing bodies have an affect on the number of practitioners and the overall level of competency for entering the occupation.

There is some controversy whether practice acts actually protect the public by assuring the quality of services provided by the regulated occupation or serve the interests of the practitioners. While one study indicates that "licensing tends to enhance the capabilities of the licensed professionals, resulting in better delivered quality",[13]other studies indicate that "...the current competency control systems are not sufficient to eliminate errors in judgement, obsolete practices, and undisciplined, careless practices."[14]

Continuing education is traditionally thought of as a means of assuring continued competency and is often included as a prerequisite for credential renewal. This assumption, however, has been questioned. Colorado no longer requires continuing education for maintenance of a nursing license because the Colorado Board of Nursing found that, among other things, no nurses were identified as unsafe practitioners as a result of the mandatory continuing education program and the number of disciplinary actions for substandard care

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[13]Sidney Carroll and Robert Gaston, "Occupational Licensing and the Quality of Service", Law and Human Behavior, Vol. 7, Nos. 2/3. 1983, pp. 139-146, p. 145.

[14]Gary Gaumer, "Regulating Health Professionals: A Review of the Empirical Literature", Milbank Memorial Fund Quarterly, Vol. 62, No. 3, 1984, p. 395.

continued to rise despite the continuing education requirement.[15] Additionally, the National Council of State Boards of Nursing stated that there was still "no research showing any correlation between mandatory continuing education and continued competence of any licensed group."[16] Despite the controversy, most practice acts require a certain amount of continuing education in order to renew credentials.

Although the use of minimum education and training requirements as the basis for credentialing is questioned as a quality assurance measure, it does appear to assure that regulated practitioners have at least a basic level of competency in a particular occupation.

QUALITY - FINDING 1b

The credentialing system provides a necessary mechanism for consumer protection, consumers may file complaints against practitioners and practitioners are disciplined through the credentialing system.

The designation of standards of practice and grounds for discipline are another quality assurance function of occupational regulation. Practitioners who fail to meet the standards of practice set forth in the practice act may be subject to disciplinary action, including revocation of their credential. Occupational regulation also establishes a credentialing entity which serves as a mechanism for resolution of consumer complaints. In the absence of occupational regulation the consumer has little recourse for resolving complaints against practitioners.

An individual consumer can pursue a civil lawsuit against an individual practitioner to remedy a harm and may receive the remedy. Occupational regulatory systems, however, hold the practitioner responsible to society as a whole for their behavior.

Standard of practice provisions focus primarily on ethics or professional conduct rather than attempting to set parameters for performance of specific occupational tasks. There is usually a general provision in the practice act which allows the credentialing entity to discipline a practitioner for a departure from the minimum standards of acceptable and prevailing practice of the occupation.

Disciplinary actions identified in practice acts are varied but usually include limitation of a credential, conditioning of the credential, censure or reprimand, suspension or revocation. A review of the biennial board reports indicates that very few credential suspensions or revocations occur, with the boards opting for alternative disciplinary actions described below depending on the unique circumstances involved.

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[15]"Mandatory CE for Nurses Ends in Colorado, But Debate Continues", Health Professions Report, 29 August 1994.

[16]ibid.

QUALITY - FINDING 1c

Some recent national reports indicate disciplinary actions taken by credentialing agencies are predominantly for unprofessional and unethical conduct or legal violations rather than for incompetent or poor quality practice. We could not determine the extent to which Minnesota practitioners are disciplined for incompetent practice as compared to unethical or unprofessional conduct.

Although disciplinary actions are one method of assuring the quality of services provided by regulated practitioners and protecting consumers from incompetent practitioners, there is some dispute whether this is being accomplished. Regulatory agencies have been criticized for revoking licenses primarily for ethics violations rather than for incompetent practice.[17] They are perceived as reluctant to take disciplinary action where incompetence is identified, thus compromising their role in assuring practitioner competency.[18]

Additional criticism comes from the Public Citizens' Health Research Group which periodically prepares a report on Medical Boards throughout the country, rating them using "serious" disciplinary actions as a measure of the effectiveness of the consumer protection or quality assurance function of the Boards.[19] "Serious" disciplinary actions include license revocations, suspensions, probations, surrender of license, loss of privileges, limitation or restriction of license or licensed privileges.[20] Other interim disciplinary measures taken by the Boards were not included in the tally of disciplinary actions.

Critics of a previous version of the study stated that the Group did not give enough credit to the Boards for alternative actions they may have taken to discipline practitioners.[21] They are of the opinion that hard numbers (i.e. comparisons of the ratio of actions taken to the number of licensed physicians in the state) isn't a fair measure of board effectiveness because the philosophy on discipline varies from state to state. One state may take a more serious action against a physician than another state based upon a philosophy of rehabilitation rather than punishment of the practitioner.

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[17]ibid., p. 390.

[18]ibid., p. 398.

[19]Public Citizens' Health Research Group, Comparing State Medical Boards, (Washington D.C.: Public Citizens' Publications, 1993)

[20]ibid., p. 7.

[21]James Gray, "Why Bad Doctors Aren't Kicked Out of Medicine", Medical Economics, January 20, 1992, pp. 126-149, p. 141.

Additional factors evaluated by the Group to determine the effectiveness of occupational regulation in a particular state included reporting requirements; the standard of proof needed to substantiate disciplinary actions; public access to information regarding disciplinary actions; information sharing with peer organizations, other boards, the AMA, the American Osteopathic Association, area hospitals, state hospital associations, state medical and osteopathic societies, the DEA, the state human services department, law enforcement authorities, local media, and clinics or hospitals where the physician has privileges; and the type of information available to consumers regarding a particular physician's licensure status.

The study concluded with recommendations for federal and individual state action in order to improve the consumer protection function of occupational regulation.[22] Recommendations for federal action included the creation of grants for boards to work on performance standards such as complaint processing time, public information, consumer representation on the board, publication of a newsletter with the names of disciplined practitioners and descriptions of discipline. They also made suggestions for increased aggressiveness of Medicare peer review organizations, an opening of the National Practitioner Data Bank to consumers, provision by the DEA a list of practitioners it has disciplined, and required recertification for Medicare physicians. For Minnesota, the Group specifically recommended that licenses of physicians who are out of compliance with previous board orders be immediately suspended. It also suggested legislative action to allow probation as a disciplinary alternative and to require that all formal disciplinary actions be made public. The Group recommended that the Board of Medical Practice include a list of recently disciplined physicians in its newsletter and send immediate notice to hospitals and state and federal agencies of physician offenses and board actions.

Review of biennial reports reveals that Minnesota credentialing agencies generally do discipline for unprofessional or unethical conduct rather than incompetency. Minnesota practice acts, however, do not always differentiate incompetency from unethical or unprofessional conduct. For example, physician licensing laws do not specify incompetency as grounds for discipline. Grounds for physician discipline do include unethical and unprofessional conduct.[23] Unethical conduct is further defined as including "... medical practice which is professionally incompetent...".[24] Unprofessional conduct includes "...the failure to conform to the minimal standards of acceptable and prevailing medical practice...".[25] Based upon the statutory language in the practice acts and the reporting format for the boards, it is difficult to accurately determine what proportion of disciplinary actions are for incompetency. In general, disciplinary measures seldom include revocation or

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[22]Comparing State Medical Boards, p. 30.

[23]See Minnesota Statutes, §147.091.

[24]Minnesota Statutes, §147.091, subdivision 1(g).

[25]Minnesota Statutes, §147.091, subdivision 1(k).

suspension of a credential but instead consist of limiting, conditioning or restricting a credential; probation; reprimand; or warning.

QUALITY - FINDING 2

Some of the more effective "quality" provisions contained in practice acts include reporting requirements and temporary suspension clauses.

Several practice acts contain provisions which would appear to provide quality assurance. Specifically, there are reporting requirements for certain occupations which require the reporting of unprofessional or incompetent practitioners to the appropriate credentialing agency. Reporting requirements perform a quality assurance function by increasing the likelihood that incompetent or unprofessional conduct will be reported to the appropriate credentialing agency. Temporary suspension clauses in a few of the practice acts allow a credentialing agency to suspend a practitioner's credential prior to any hearing in cases of an immediate threat to the public health or safety. Their importance lies in the ability of the credentialing agency to take immediate action to remove a practitioner from practice. As noted below, not all practice acts contain reporting requirements or temporary suspension provisions.

QUALITY - FINDING 2a

Reporting clauses in some practice acts require practitioners to report other practitioners who are performing incompetently or unprofessionally. This could also be very effective for protecting the public but it is not a part of all practice acts.

Reporting requirements are included in the practice acts for chiropractors,[26] social workers and marriage and family therapists,[27] nurses,[28] podiatrists,[29] and physicians.[30] The reporting provisions are quite similar. Typically, individuals are permitted to report a practitioner to the appropriate board if there may be grounds for discipline. Reporting is required of professional societies, licensed professionals, insurers, courts, and institutions. Self reporting is required for chiropractors, marriage and family therapists, social workers and physicians.

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[26]Minnesota Statutes, §148.102.

[27]Minnesota Statutes, §148B.07.

[28]Minnesota Statutes, §148.263.

[29]Minnesota Statutes, §153.24.

[30]Minnesota Statutes, §147.111.

Professional societies must report any actions taken against a practitioner as well as any practitioners they believe to have violated their respective practice act. Licensed professionals must report anyone who they believe has violated a practice act. Insurers must report any malpractice settlements or awards made against a practitioner. Courts are generally required to report judgements of mental illness or incompetency, felony conviction, fraud or abuse convictions, or the commitment of a practitioner or appointment of a guardian for the practitioner. Four practice acts require the court to report any convictions related to narcotic abuse or violation of the controlled substances act. The nursing practice act also requires reporting DWI convictions. Institutions must report any actions taken against practitioners to limit their practice privileges or any voluntary resignation of a practitioner while a disciplinary action is pending. Reports are required within 30 days of the occurrence of the reportable event except for insurers which are generally required to report quarterly.

Chiropractors, marriage and family therapists, social workers and physicians are exempt from reporting other practitioners if they acquire information within the context of a patient relationship and successfully counsel the practitioner to limit or withdraw from practice.

All practice acts with reporting requirements contain corresponding clauses providing immunity from civil liability and criminal prosecution for reporting or investigating a complaint filed under the reporting provision.[31]

Reporting requirements have been shown to increase the number of complaints from fellow practitioners.[32] The use of reporting requirements in combination with immunity provisions is encouraged by the Public Citizen's Health Research Group as a consumer protection measure.[33] There is some concern, however, that expanded reporting requirements would interfere with the confidentiality of the therapeutic relationship and the function of the ethics committee of a professional association.[34]

Reporting requirements expand the credentialing agency's sources for information about unprofessional or incompetent practitioners beyond consumer complaints. The entities required to report may also be able to more accurately identify unprofessional and incompetent behavior. These reporting requirements place increased responsibility on

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[31]See Minnesota Statutes, §§148.103 (chiropractors), 148B.08 (social workers and marriage and family therapists), 148.264 (nurses), 153.25 (podiatrists) and 147.121 (physicians).

[32]Gray, James, p. 126.

[33]See Comparing State Medical Boards.

[34]See Jane Thomas, "Mandated Reports of Ethics Violations: What Psychologists Need to Know", Minnesota Psychologist, September, 1994.

practitioners to monitor their own occupation. Overall, the reporting requirements would appear to provide additional consumer protection and quality assurance.

QUALITY - FINDING 2b

A "temporary suspension" clause in several of the practice acts would appear to be an effective means for protecting the public. This measure, however, does not appear to be used very often.

Many Minnesota Practice acts contain temporary suspension clauses.[35] The typical provision allows the credentialing agency to suspend the license of a practitioner without a hearing for a limited period of time when there is a "serious risk of harm" or "risk of imminent harm". The licensing board must find that the practitioner has violated a statute or rule which the board is empowered to enforce and must provide written notice to the practitioner specifying this statute or rule. The time frame for holding a subsequent disciplinary hearing varies, with some boards holding internal hearings before the required contested case hearing.

A review of the biennial board reports indicates that this provision is not frequently invoked. The major impediment to using this provision is the abbreviated time frame the credentialing agency has for preparation of the case for hearing. A 30 day time frame does not allow complete development of the case by the agency. Additionally, the credentialing agency essentially must prepare their case against the practitioner and present it at the temporary suspension hearing and again at any hearing for a permanent action against the practitioner. Unless there is a definite and great risk of harm if the practitioner continues to provide services, the credentialing agency will complete its investigation and preparation for a final action rather than a temporary suspension.

Despite its disadvantages, the temporary suspension clause does provide one more disciplinary option for credentialing agencies to use. This option could be an even more effective means of public protection if the law allowed credentialing agencies more time to prepare for a temporary suspension hearing.

QUALITY - FINDING 3

There is no mechanism for assuring the quality of or protecting the public from the acts of unregulated health care practitioners with the exception of the Office of Mental Health Practice which provides protection to the public from unlicensed mental health practitioners.

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[35]Minnesota Statutes, §§148.10, subdivision 4 (chiropractors); 150A.08, subdivision 8 (dentists, dental hygienists, and dental assistants); 148B.175, subdivision 7 (social workers and marriage and family therapists); 148.98, subdivision 3 (psychologists); 148.262, subdivision 3 (nurses) and 153.22 (podiatrists).

Practice acts regulate only a specific type of practitioner. Licensure acts define the scope of practice and prohibit unlicensed individuals from performing acts describe within the scope of practice. Individuals performing related tasks outside the described scope of practice are not under the jurisdiction of the credentialing agency. For all practical purposes, a licensing board can enforce the scope of practice against a non-licensed individual if unlicensed practice is a criminal act and a county or city is willing to prosecute. In licensure, the credentialing agency may not take enforcement action against an individual as long as their activities remain outside the scope of practice.

Registration acts prohibit the use of protected titles, however, individuals are free to perform tasks associated with the registered occupation as long as they do not use any of the protected titles. Again, the credentialing agency does not have jurisdiction over these individuals and may not take enforcement action against them.

Individuals in jobs associated with regulated occupations but who have no credentialing system of their own are presently outside the jurisdiction of any credentialing agency. Individuals who are not performing licensed activities or who are not using protected titles remain free to continue to provide their services without the oversight of any credentialing agency, leaving consumers without a forum for complaint resolution.

The Office of Mental Health Practice, however, is an example of one mechanism of consumer protection which can affect those individuals who are currently unregulated. It provides information to consumers which enables them to be more knowledgeable about the type of services they can expect. It provides a forum for consumers who have been harmed by a practitioner. It is not restricted to a specific scope of practice but has jurisdiction over persons who participate in prohibited conduct. Finally, there are strong reporting requirements, with the corresponding immunities to encourage a flow of information to the Office.

The Office of Mental Health Practice was established within the Department in 1991. The Office was established to receive complaints from consumers about the activities of unlicensed mental health practitioners and take disciplinary action against practitioners.[36] The law contains a list of prohibited conduct for which the practitioner may be disciplined by the Department.[37] The Commissioner is specifically prohibited from establishing education and training requirements as prerequisites to practice. Other components of this program include a public education component to inform consumers about mental health services in general. Reporting requirements (and complementary immunity provision) are also established.

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[36]See Minnesota Statutes, §148B.60 et. seq.

[37]Minnesota Statutes, §148B.68.

Since its inception in 1991, the Office has served as a clearinghouse for mental health services information to consumers and handled complaints against unlicensed practitioners. The Office has received 497 oral and written complaints. Of this number, 229 complaints have been closed. One hundred sixteen (116) complaints have been investigated, resulting in enforcement actions on 29 complaints involving ten practitioners. Currently 173 written complaints remain open pending investigation or enforcement action. Because of limited resources, complaints are prioritized and those dealing with sexual abuse are investigated first. The remaining complaints form a growing backlog while awaiting investigation.

Although this type of regulatory system provides strong consumer protection, there are several administrative disadvantages. This regulatory scheme is not fee supported as are other regulatory systems; it is dependent on general fund appropriations. Like its credentialing agency counterparts, the investigative and disciplinary functions are labor-intensive, requiring substantial staff time and resources. Because there is no issuance of a credential, jurisdictional authority of the Department over the practitioner must be established in each case.

B. COST

There are several sources of financial information about credentialing agencies, however, they do not provide a complete picture of the cost of occupational regulation. Although credentialing agencies may initially collect and record information in a form which allows analysis of the cost of regulating each occupation, this detailed information is incorporated into larger reports and is only retained for a limited period of time. Secondly, the information contained in agency reports or records reflects the cost of regulation for practitioners; it does not provide an accurate index of the costs of regulation to consumers. Information regarding prices for services provided by specific occupations was not located.

The primary sources used for this report are Fee Reports for fiscal years 1989 through 1992, Departmental Earnings Reports from 1993 to present, biennial board reports from 1990 to present and expenditure records of the Department of Health.

The biennial board reports required by Minnesota Statutes, §214.07, subdivision 1 provide a source of total disbursements by a board for a particular fiscal year. Information was obtained from Department of Health expenditure records for those occupations regulated by the Department of Health. Table 6 in Appendix C indicates the total disbursements of the various credentialing agencies for fiscal years 1989 through 1992.

COST - FINDING 1

Based upon the available financial information, it is not possible to determine the total cost of occupational regulation in Minnesota over the past five years.

There is insufficient information which would allow a specific determination of the effects of occupational regulation on the cost of services in Minnesota. It is assumed that occupational regulation indirectly increases the cost of services for the consumer because regulated practitioners need to pay for their cost of becoming credentialed. This cost not only includes the actual credentialing fee, but also includes the expense of obtaining education or training to meet and maintain credentialing standards. These costs are eventually passed on to the consumer in the form of higher health care costs. Accurate information on changes in the price of services offered by a particular occupation over time compared to the actual costs of regulation incurred by practitioners is needed to determine the cost of occupational regulation to consumers.

COST - FINDING 2

The ongoing costs of regulating occupations are not constant and can fluctuate greatly in response to changes in credentialing standards and level of disciplinary activities.

Certain aspects of occupational regulation are steady and predictable with costs easy to calculate. There are, however, several unpredictable elements as well. A substantial change in credentialing regulations will increase costs as will unexpected or complicated disciplinary actions.

An established credentialing agency is able to predict with some certainty the number of practitioners who will be using the system and has a routine for dealing with credentialing, renewal of credentials, and receipt of complaints. When the status quo is altered by a change in the regulatory structure, additional costs are incurred to adapt the administrative system. The number of complaints and severity of complaints can fluctuate easily, adding unexpected costs to the regulatory system. This unpredictability makes it difficult to accurately budget for administration of the regulatory system.

An example of the impact of disciplinary actions upon the cost of regulation can be found in the hearing instrument dispenser regulation system. Consumer complaints to the Attorney General's office averaged 36 over a two year period. The actual number of complaints received by the Department averaged 120 per year in the first three years of operation of registration and permit system. The fees collected did not cover the administrative costs associated with processing these complaints, necessitating adjustment in the fees.

COST - FINDING 2a

Establishing new or substantially changing credentialing regulations temporarily but significantly increases the cost of regulating.

Developing a new credentialing system involves substantial cost. Many, but not all, credentialing systems are established by the administrative rulemaking process. Even those credentialing systems established by statute often require rulemaking to implement

Since its inception in 1991, the Office has served as a clearinghouse for mental health services information to consumers and handled complaints against unlicensed practitioners. The Office has received 497 oral and written complaints. Of this number, 229 complaints have been closed. One hundred sixteen (116) complaints have been investigated, resulting in enforcement actions on 29 complaints involving ten practitioners. Currently 173 written complaints remain open pending investigation or enforcement action. Because of limited resources, complaints are prioritized and those dealing with sexual abuse are investigated first. The remaining complaints form a growing backlog while awaiting investigation.

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credentialing. Compliance with this process to obtain a valid set of regulations involves a great deal of time, effort, and resources. Staff must work with interested parties in addressing any issues surrounding regulation of a particular group. Draft rules are then reviewed by Attorney General Counsel at a cost to the agency. After the rules are approved by the Attorney General Counsel, they are published in the State Register, again at cost to the agency. Should a public hearing on the rules be required, additional Attorney General expenses will be incurred as well as expenses of the Office of Administrative Hearings.

Once the rules are in place, initiation of the credentialing system involves additional cost to the credentialing agency. Staff must meet with the Advisory Council, if one is established, to finalize procedures for implementing the credentialing system. Initial applications must be developed and processed. A database must be created and practitioners educated regarding the regulatory system.

The Speech-Language Pathologist and Audiologist registration system provides an example of initial implementation costs of occupational regulation. The rules became effective and an Advisory Council was appointed by the Commissioner. The Advisory Council requested resolution of several issues surrounding registration before beginning to register practitioners. Department staff expended considerable time and energy researching and resolving the issues. Additional staff time was absorbed in preparation of application forms for Advisory Council review and approval. Once the forms were developed, it was the responsibility of Department staff to distribute information and registration material to practitioners throughout the state. Staff reviewed application forms and answered questions from individuals regarding the application process and the registration system. Finally, staff mailed out registration to approved applicants. After the initial influx of applicants, staff was able to use the forms developed and procedure established to process subsequent applications.

Rule writing costs are eventually recouped through a surcharge on practitioners, however, ongoing expenses occur while the credentialing system is being developed and continue to accumulate without offsetting income to the agency. Start-up procedures are generally one time expenses with the program running more efficiently once it is in place.

Similar costs are incurred when substantially changing an existing credentialing system. Rulemaking costs for the necessary changes are incurred as well as costs for educating current practitioners regarding the changes and adjustments in procedures.

COST - FINDING 2b

Costs for disciplinary actions are an increasing concern for credentialing agencies, as evidenced by some boards highlighting the costs of AG services in their recent biennial reports.

The cost of enforcing the established standards of practice varies tremendously and can be very expensive for the credentialing agency. The number and type of complaints can

cause great variation in costs for this function. An unexpectedly large number of complaints strains staff and resources previously allocated to complaint processing and investigation. A single complex complaint or complaint that results in a contested case hearing can absorb a significant amount of agency time and resources. Attorney General time and resources are needed to resolve complaints, resulting in additional expenses for the credentialing agency. Contested case hearings result in additional Attorney General expenses and Office of Administrative Hearings costs. Evidence of this is seen in several biennial board reports which highlight the Attorney General expenses involved. There is virtually no way to accurately plan or budget for this type of activity because of its unpredictable nature.

COST - FINDING 3

Occupational regulation must be entirely fee supported as required by Minnesota Statutes, §214.06. This means that all occupational regulation costs are ultimately paid for by consumer payments for services.

Minnesota Statutes, §214.06 requires the Commissioner and licensing boards to adjust fees so that the total fees collected by the credentialing agency as closely as possible equal anticipated expenditures during the fiscal biennium. Expenditures for regulation include a variety of elements. Per diem costs for board members while performing board business are a part of these expenditures. Staffing of the board offices to perform the necessary administrative functions (processing applications, complaint handling, support for board members) is included. Physical facilities/office space for staff are also an expenditure for the board. A large and increasing cost for many of the boards is the service of the Attorney General's office in processing complaints and enforcing disciplinary actions.

Credentialing agencies are also required by statute to recover all costs of rulemaking which initiate or modify regulation of a health-related occupational group through fees paid by the group over a period of five years.[38] Any time there is a rulemaking procedure, the fees charged the licensees will be increased to recover the rulemaking costs. Since rulemaking can be an expensive proposition, especially if a rulemaking hearing is necessary, the resultant fee increase has the potential of being substantial. It is speculated that these fee increases are eventually passed on to the consumer in the form of increased prices for services.

COST - FINDING 4

Cost control measures for the services provided by regulated practitioners are not addressed within the practice acts.

Although cost containment measures are a primary concern for health care reform, regulation of the cost of services through practice acts is very limited. Health care reform measures attempt to control cost through measures such as growth limits or practice

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[38]Minnesota Statutes, §214.06.

parameters. Those practice acts which contain provisions regarding the cost of services, attempt to regulate business practices such as advertising, billing or fee splitting.

Advertising regulations, which usually consist of a prohibition against false or misleading advertising, exist for psychologists,[39] physicians,[40] chiropractors,[41] and dentists.[42] Billing practices are addressed in the practice acts for psychologists,[43] physicians,[44] and chiropractors.[45] Provisions regarding billing practices are focused on preventing fraudulent and abusive practices rather than setting any cost control guidelines. Fee splitting is prohibited for psychologists,[46] physicians,[47] chiropractors,[48] and dentists.[49] The provisions in place which arguably address the cost aspect of services provided do not attempt to influence the actual cost of services but instead are focused on preventing misleading or fraudulent practices.

C. ACCESS

Although practice acts and occupational regulatory systems do not directly address the issue of consumer access to health care services, they can affect this access. Regulatory requirements may affect the number of individuals that are able to acquire credentialing and remain in practice. Complex regulatory systems may make it more difficult for consumers to know which practitioners are recognized by the state as meeting minimum requirements.

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[39]Minnesota Statutes, §148.96.

[40]Minnesota Statutes, §147.091, subdivision 1(e).

[41]Minnesota Statutes, §§148.10, subdivision 1(1) and 148.10, subdivision 21(g), Minnesota Rules, parts 2500.0200 - 2500.0500.

[42]Minnesota Statutes, §150A.11, subdivisions 2 and 3, Minnesota Rules, parts 3100.6500 - 3100.7200.

[43]Minnesota Rules, part 7200.5200.

[44]Minnesota Statutes, §147.091, subdivision 1(q).

[45]Minnesota Statutes, §148.10, subdivision 1(21)(d), (f), and (h).

[46]Minnesota Statutes, §148.93, subdivision 1.

[47]Minnesota Statutes, §147.091, subdivision 1(p), Minnesota Rules, chapter 5620.

[48]Minnesota Statutes, §148.10, subdivision 1(16).

[49]Minnesota Statutes, §150A.11, subdivision 4.

ACCESS - FINDING 1

Practice acts do not explicitly regulate consumer access to services provided by the occupation, however, occupational regulation may affect access to health care services.

A review of the practice acts does not reveal any provisions addressing access to services. It is theoretically assumed, however, that occupational regulation does have an impact on accessibility to services. "The increased cost of services, the creation of shortages of supply, and the development of maldistributions of professionals resulting from licensing laws lead to direct harm to the public through the inability of the poor and other disadvantaged groups to afford or find any practitioner at all."[50] Though dated, we were unable to find more recent research to support or refute this assertion.

A more current example of the effect of regulation on access may be found in the recent change in the regulatory scheme for Minnesota hearing instrument dispensers. It is interesting to note the effect of increasing regulation on the numbers of hearing instrument dispensers. While the hearing instrument dispensers were under a permit and registration system, there were an average of 440 hearing instrument dispensers each year. From July, 1993 to November, 1994 all hearing instrument dispensers were required to take and pass a written and practical examination in order to continue to sell hearing aids in Minnesota. Once the state instituted the certification system with the required certification examination, the number of hearing instrument dispensers dropped to 247, almost 45% fewer than the number of dispensers providing services to Minnesotans in 1993.

This illustrates that occupational regulation, with the purpose of improving the quality of providers and their services, also effects costs and access. In determining the standards for occupational regulation, consideration needs to be given and, when appropriate, attempts made to balance antagonistic effects of regulation. Adopting and implementing more stringent qualifications to practice may not serve the public if gains in provider competency do not more than offset the anticipated decrease in access to providers and increase in costs to consumers. In the example of the hearing instrument dispensers, limiting access to providers who pass the certification examination better serves the public than allowing access to providers who have not demonstrated their competency. Negative effects of regulations may be eased by careful selection of competency requirements, gradual implementation and providing, in some limited circumstances, temporary exemptions or exceptions from regulation. These options may be considered when the threat of public harm from performance of occupational functions allows for restrictive regulation.

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[50]Daniel Hogan, "The Effectiveness of Licensing", Law and Behavior, Vol. 7, Nos. 2/3. 1983, pp. 117-138, p. 121; See also Carroll, Sidney and Gaston, Robert p. 145 who state that lower socioeconomic classes tend not to receive the benefits of licensure but tend to get lower quality or no service at all.

Although the actual numbers of certified practitioners has decreased, the impact of certification and the subsequent decrease in hearing instrument dispensers on consumer access to hearing health services isn't clearly known at this time. The Department roster records the business or home address of the certifying individual and does not reflect actual practice locations. There is an insufficient amount of information available to obtain an accurate picture of the effect of occupational regulation on accessibility to health care services. Additional research is needed to determine the effects of occupational regulation on health care access.

ACCESS - FINDING 2

Very few practice acts contain a provision requiring a credentialing agency to act as an information clearinghouse to provide information to consumers about the qualifications of regulated practitioners, the services performed by particular practitioners and the means of accessing these practitioners.

Health care reform places greater emphasis on consumer responsibility for health care decisions. One of the goals of health care reform is to make health care providers and health plan companies more accountable to consumers; this implies a certain level of consumer knowledge about what they should expect to receive for health care services.[51] Based upon the direction of health care reform in Minnesota, it is clear that greater consumer education will be needed to inform consumers about the qualifications of regulated practitioners, the services performed by practitioners and the means of accessing these practitioners. A review of the practice acts indicates that the only acts which specify public education as a function of the credentialing entity are the psychology practice act,[52] the unlicensed mental health practitioner regulations,[53] and the hearing instrument dispenser regulations.[54]

D. ADMINISTRATION

Additional aspects of occupational regulation must be noted aside from its effects on quality, cost and access to health care services. In researching this report, it was noted that credentialing systems provide services to the health care community other than those intended. It is apparent that credentialing agencies are not utilizing adequate outcome measures which would allow for complete and accurate assessment of the impact of occupational regulation on health care delivery. Credentialing agencies are also caught in a

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[51]Minnesota Statutes, §62J.016.

[52]Minnesota Statutes, §148.905, subdivision 1(8).

[53]Minnesota Statutes, §148B.61, subdivision 1.

[54]Minnesota Statutes, §153A.18.

bind between performing a policy function or administering the regulatory system. Finally, there are not always sufficient credentialing criteria for addressing credentialing issues and where criteria do exist, they are difficult to apply with any consistency of results.

ADMINISTRATION - FINDING 1

Credentialing systems provide valuable services in addition to the expected consumer protection services.

Based upon statutory language and the criteria for determining whether an occupation shall be regulated, protection of the public is the primary impetus for regulation. Occupational regulation may not be imposed except to protect the public safety and well being.[55] Review of practice acts and the effects of regulation, however, reveals that occupational regulation may have different consequences, which, although not those originally intended, serve a valuable purpose.

ADMINISTRATION - FINDING 1a

Current credentialing laws appear to primarily benefit the occupation rather than the consumer. In theory licensure limits practice of a certain occupation to those meeting requirements in the practice act, potentially reducing the pool of providers and theoretically leveraging the income of licensed practitioners.

Although occupational regulation is ostensibly for the protection of consumers, it appears that primarily practitioners benefit from regulatory systems. Credentialing often allows practitioners to obtain third party reimbursement for their services. It allows third party payers to easily identify practitioners who meet minimum state standards of education and training. Even though the general consensus is that the practitioners of an occupation receive benefits as a result of being regulated, one author concludes that the reliance of licensing laws on academic credentials is discriminatory towards the poor, minorities, women, and the elderly.[56] The author asserts that because these groups are less likely to possess or be able to attain the necessary academic credentials, they are less likely to qualify as practitioners and receive the benefits of professional licensing. This research is dated, however, and staff could not locate recent literature to support or refute these assertions.

Research literature also posits that regulation, especially in the most restrictive form of licensure, limits the pool of practitioners to those with prerequisite education and or qualifications. Staff could not locate data regarding prices for services for specific groups in

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[55]Minnesota Statutes, §214.001.

[56]Hogan, Daniel, p. 133.

Minnesota; the literature theorizes that occupational regulation results in higher costs to the consumer.[57] Additionally, it has been stated that "restrictive practices invariably contribute to higher fees and practitioner incomes, thereby benefitting the protected professional groups."[58] It has been said that licensing laws are aimed at eliminating competition, rather than incompetence.[59] This research is also dated and no recent literature has been located to support or refute these assertions.

The Department acknowledges that the theories set forth above may be dated, however, the Department has relied upon these theories in evaluating requests for credentialing. Given the fact that the functions performed by the groups now requesting credentialing generally pose less threat to the public than medical or nursing functions, perhaps these theories are even more appropriately applied today.

ADMINISTRATION - FINDING 1b

Credentialing is often required for third party reimbursement of the services provided by practitioners.

Eligibility for third party reimbursement is often associated with professional credentialing. The Minnesota Department of Human Services, (DHS), requires practitioners be credentialed by the state in order to be enrolled as providers in their health care system. DHS bases its policy decision on the fact that federal regulations require practitioners be licensed by the state in which they practice in order to receive federal funds. DHS, therefore, limits provider enrollment to practitioners credentialed by the state.

Private sector health plans also link state credentialing of an occupation to eligibility for participation as a plan provider. Health plan companies have a bit more flexibility than DHS and are able to create their own internal criteria for accepting practitioners into their provider network. Health plan companies are able to develop criteria for accepting those practitioners whose occupations are not credentialed by the state.

ADMINISTRATION - FINDING 1c

The credentialing system provides a "service" to health plans, insurers, facilities, third party administrators and others to identify practitioners who meet standards of education and training.

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[57]"[L]icensing has been shown repeatedly to have an upward price effect." Carroll, Sidney and Gaston, Robert, p. 140.

[58]Gaumer, Gary, p. 406.

[59]Hogan, Daniel, p. 121.

Health plan companies utilize the existing state credentialing system to assist their evaluation of practitioners requesting/applying for enrollment as providers. State credentialing agencies are relied upon by these entities as having verified the educational and professional qualifications of the individual practitioner. Health plan companies also check the state credentialing agency for information regarding any disciplinary actions against the practitioner. The state practice acts are also referred to by health plans when determining whether a provider is working within his or her scope of practice. Conversations with several health plan company representatives indicates their reliance on state entities for this information will continue.

The Minnesota Department of Human Services, administrator for medical care programs, also utilizes the state credentialing system as one criteria for determining provider enrollment in state benefits programs. DHS necessarily relies more heavily on criteria mandated in federal regulations in order to maintain eligibility for federal funds. Federal regulations often specify "licensure" as a professional credential rather than the less restrictive form of regulation found in registration, certification or permit systems. Compliance with federal law necessarily requires DHS to restrict its enrollees more than state law does. Conversations with representatives from DHS indicate that, barring any unforeseen changes in federal law, they will continue to rely on state credentialing systems as a basis for determining provider enrollment in state medical benefits programs.

ADMINISTRATION - FINDING 1d

Credentialing creates a database of practitioners which facilitates the monitoring of practitioner geographic distribution and specialty, assisting with consumer access to necessary health care services.

Until recently, there has been a lack of adequate monitoring of the geographic distribution and specialty of health care practitioners. Efforts in the past to obtain this information have been centered in the Health Economics Program of the Minnesota Department of Health. The Health Economics Program published a report in 1991 which showed the location of various practitioners within the state on the county level.[60] This report recommended that the Department maintain data on the supply and characteristics of health personnel regulated by the state, obtaining information through the health professions registration and licensing systems.[61]

The Department's Office of Rural Health and Primary Care, in coordination with the Board of Medical Practice, has recently completed a comprehensive survey of physicians

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[60]Minnesota Department of Health, Health Systems Development Division, Health Economics Program, Providing Medical Care in Rural Minnesota: Recommendations for Meeting Health Personnel Needs, (Minneapolis, MN, March, 1991).

[61]ibid., p. 173.

using license renewal forms as a means of obtaining the necessary practice information from physicians. Creation of this database will allow the monitoring of physicians and eventually assist with assessing and planning for consumer access to physician services. It would not have been possible to obtain the necessary information about physicians without the existence and cooperation of the Board of Medical Practice. The Department is continuing to work with other licensing boards in collecting information on additional occupations to develop a health professional database.

Based upon the experience of the Department, occupational regulation systems are essential to assist with the creation of an accurate database for monitoring geographic distribution and specialty of providers. The database of practitioners allows one to see where they are located in relation to the population who needs their services. By monitoring practitioner demographics, current and future shortage and surplus areas can be identified, providing the basis for better health care planning.

There may be difficulties associated with obtaining similar information using a registration system since individuals may continue to provide a particular service without being registered as long as they do not use a protected title. Surveys of registered occupations may need to include additional means of locating and identifying unregistered individuals in active practice within the state.

ADMINISTRATION - FINDING 2

Current outcome measures provide limited information for accurately determining the impact of occupational regulation on health care reform goals dealing with the quality, cost and access to delivered health care services.

The state uses the biennial reports submitted by the various health-related boards to evaluate how effectively occupational regulation is working. The outcome measures contained in these reports focus on entry level qualification screening (examination and subsequent credentialing) and disciplinary actions. The biennial reports contain only minimal information regarding the cost effectiveness of occupational regulation. No measures of accessibility to the services provided by a particular occupation are required to be included in the biennial reports. Thus, performance measures currently used by credentialing agencies provide very limited information about the effects of occupational regulation on health care reform goals.

ADMINISTRATION - FINDING 2a

The biennial reports submitted by the credentialing boards do not contain performance measures related to the cost-effectiveness of occupational regulation.

Minnesota Statutes, §214.07 outlines the requirements for the contents of the biennial reports filed by the health-related licensing boards. The contents include items related to

board meeting activity, board staff, examination activity, licensing activity, and complaints and disciplinary activity. The only item related to the cost-effectiveness of regulation addresses the receipts and disbursements of board funds for the biennium. There are no more specific items contained in the biennial report which would permit an assessment of the cost-effectiveness of occupational regulation. If one of the purposes of the biennial board reports is to provide information regarding the effectiveness of occupational regulation, items that address cost-effectiveness should also be required in the biennial report. It is unclear at this time what items would be included to provide information regarding the cost-effectiveness of occupational regulation.

ADMINISTRATION - FINDING 2b

Information about performance outcomes for occupational regulation, as measured by biennial reports, is limited to credentials applied for and issued or denied, examination results, and disciplinary data.

The biennial reports are required, among other things, to include information which provides information on the boards' credentialing and disciplinary functions. The number of persons examined by the board, the number of persons credentialed by the board following examination, the number of persons not credentialed after the examination, and the number of persons credentialed without taking the examination are required items for the report.[62] Disciplinary data consists of the number of complaints, a summary of complaints by category, responses to complaints and any alterations in the status of credentials (such as revocations or suspensions).[63] Additional or alternative measures of the quality control function of occupational regulation are not required at this time for the biennial reports. Additional functions may need to be measured and included in order to give a better picture of the effectiveness of occupational regulation.

ADMINISTRATION - FINDING 2c

Disciplinary outcomes are not defined and therefore data is not uniform or consistent among credentialing agencies.

Minnesota Statutes, §214.07 requires the submission of information on the dispositions of complaints received by the board but does not require specification of board actions other than revocation, suspension, or changes in the status of a credential. This results in the different boards reporting complaint resolution differently from each other. "Complaints" are not defined consistently across the different boards nor are the actions taken against practitioners consistently defined. These inconsistencies make it difficult to interpret or summarize the information provided by the boards regarding disciplinary actions.

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[62]Minnesota Statutes, §214.07.

[63]ibid.

ADMINISTRATION - FINDING 2d

Occupations regulated by the Department of Health are not required to file reports under §214.07.

Minnesota Statutes, §214.07 requires "health-related licensing boards" to file biennial reports to the legislature and governor. The definition of "health-related licensing board" contained in Minnesota Statutes, Chapter 214 includes reference to the chemical dependency counseling licensing advisory council and the mental health practitioner advisory council. The remainder of the occupations regulated by the Department such as asbestos contractors, emergency medical technicians, environmental health sanitarians, hearing instrument dispensers, morticians, plumbers and water conditioner operators, speech-language pathologists and audiologists, water supply operators and water well contractors are not required to file a biennial report even though they perform many of the same functions as the health-related licensing boards. The same type of information is needed from all of the credentialing agencies regulating health-related occupations in order to obtain a complete picture of occupational regulation in Minnesota.

ADMINISTRATION - FINDING 3

A variety of administrative structures for regulating occupations exist without any apparent rationale for differences in organization. There is a need to clarify the rationale/or develop policy for determining the method of administration.

Currently there are a number of administrative structures used to regulate occupations. Independent boards regulate physicians, nurses, chiropractors, dentists, nursing home administrators, psychologists, marriage and family therapists, social workers, optometrists, podiatrists, and pharmacists. Additional health-related occupations are regulated as an adjunct to an independent licensing board with an advisory council. These occupations include physical therapist, physician assistants, respiratory care practitioners, dental hygienists, and dental assistants. The Department of Health regulates speech-language pathologists, audiologists, chemical dependency counselors and hearing instrument dispensers with the assistance of advisory councils.

As can be seen, there are a variety of administrative structures used to regulate health-related occupations. Aside from the general principle of regulating in the least restrictive manner, the only guidance for determining the type of regulation that should occur is found in a directive in Minnesota Statutes, §214.13, subdivision 4 to the Commissioner to delegate regulation activities to an existing board with the concurrence of that board. There are no other criteria in statute which would provide guidance for the legislature or the Commissioner in determining which type of administrative structure is most efficient for a particular occupation. In addition, given that there are so many occupations regulated by different entities, there is no overall policy to guide future decision-making regarding regulation of additional occupations.

ADMINISTRATION - FINDING 4

Credentialing agencies encounter conflict between their policy function in occupational regulation and their regulatory function.

The credentialing agency not only serves a regulatory function by administering the credentialing system, it is also required to make policy decisions which, at times may be in conflict with its regulatory function. The agency may be requested to make decisions regarding scope of practice, disciplinary procedures or occupational regulation which place it in the middle of conflict between opposing principles.

An agency may be requested to make a public policy determination about a scope of practice issue concerning the practitioners it credentials. The Board of Psychology's determination to increase the entry level requirements for a psychologist license is an example of this type of decision. The agency responsible for administering the licensing system for psychologists was involved in the decision to increase entry level requirements for its licensees. Recently the Department had to deal with the issue of requiring audiologists to take the hearing instrument dispenser certification examination in order to dispense hearing aids. The Department has administrative responsibility for the speech-language pathologist and audiologist registration system and the hearing instrument dispenser certification system but must also make decisions regarding public health policy in relation to hearing health protection.

A credentialing agency may face conflict in the area of practitioner discipline. The agency has a responsibility to protect the public from unfit practitioners. It also may have a commitment to rehabilitating practitioners so they may continue to pursue their livelihood and provide service to their community. The conflict between these principles may make it difficult for the agency to administer the credentialing system at times.

The credentialing agency has an interest in avoiding radical changes in the regulatory scheme because of its investment in the current system. This interest may impair the objectivity of the credentialing agency in policy analysis regarding the regulatory system.

ADMINISTRATION - FINDING 5

The criteria in Minnesota Statutes, Chapter 214 for determining occupational regulation are difficult to apply. They involve complex relationships among elements pertaining to cost-effectiveness and risk of harm; the effects of regulation on the various criteria are imprecise. Reasonable minds may differ markedly on how to weigh the criteria and their elements.

The multiple criteria set forth in statute and further developed by rule are complex and difficult to accurately apply to any particular occupational group requesting review. It is often difficult to determine how the different factors will interact. Different conclusions may be reached based upon the same information and using the same criteria for balancing the

criteria against each other. Under the review process with an active Human Services Occupations Advisory Council there were several times that the Advisory Council and Department staff would come to different conclusions regarding whether a group should be regulated or how the group should be regulated. At times the Commissioner came to an even different conclusion, all based upon the same information presented and using the same criteria to make the decision.

V. CONCLUSION

In the beginning sections of this report several questions were posed regarding health occupations regulation and health care reform. This report attempted to identify whether health care reform goals would stimulate additional occupational regulation and how the Department should respond to occupational groups seeking regulatory recognition as providers. The effects of occupational regulation were questioned to determine whether occupational regulation has discernable, positive effects on the quality, cost and access to delivered health care services. Finally, the outcomes of occupational regulation were examined to determine whether there is a need to revise the legislative policy concerning occupational regulation articulated in M.S. §214.001.

It is unclear whether health care reform efforts will stimulate additional requests for occupational regulation. It appears at this time that the unregulated occupational groups seeking regulation do not pose threat of serious harm to health care consumers, which has been the criterion Department staff have weighted most heavily in evaluating the need for regulation. However, new emphasis on cost containment and access in health care reform may be reason to give more weight to cost benefit criteria than in the past. The effects of health care reform need to be monitored and analyzed to determine whether additional occupational regulation is necessary. The Department proposes a moratorium on further credentialing activity until the role and effectiveness of occupational regulation in a reformed health care system can be clarified.

It is difficult to determine the exact effect of occupational regulation on the quality, cost and access to health care services because of inadequate measuring instruments. Quality measures consist mainly of disciplinary actions taken by boards in response to complaints. Disciplinary information reported by health-related licensing boards does not adequately represent the job they are doing in protecting the public from unfit practitioners. We were unable to determine the cost of regulating occupations over the past five years because of limited detailed financial information. Finally, there are no provisions in the practice acts which address access to services although the practice acts arguably impact upon access to services.

Despite the above-mentioned inadequacies of the reporting system, it can be concluded that there are several positive effects of the regulatory systems currently in place. Credentialing programs set minimum requirements for practitioners. They provide a mechanism for consumers to obtain relief from practitioners who violate the laws. Credentialing systems also allow for the accumulation of demographic data on practitioners which may later be used in addressing access issues. Credentialing systems are also utilized by third party payers in screening qualifications of practitioners.

Further information gathering and discussion are needed to adequately assess the effects of credentialing criteria in Minnesota Statutes, Chapter 214. These criteria were developed approximately two decades ago and may not accurately reflect the factors

important in occupational regulation and health care reform today. The Commissioner recommends a moratorium during which time the Department and the health-related licensing boards should work together to review credentialing policies and develop performance measures for occupational regulation.

The ability to implement the recommendations which follow may be compromised by budget decisions to be made in the 1996-1997 biennium. Accomplishing the recommended activities will depend on the Legislature's awareness, responsiveness and commitment to occupational regulation issues. The Department acknowledges the discrepancy between the Legislature's need to have the Department evaluate and determine appropriate regulation of allied health occupations and the need to reduce state expenditures in times of limited resources.

VI. RECOMMENDATIONS

Based upon the discussion and findings above, the Department recommends the following:

RECOMMENDATION 1

The legislature should declare a moratorium on further regulation of allied health occupations until the Minnesota Department of Health and the health-related licensing boards collect evidence of the effects of existing regulations on health care quality, access and costs as detailed in the recommendations which follow.

A moratorium should be declared on further regulation of allied health occupations. Based upon the information available, it is not clear what the impact of occupational regulation is on health care services nor is it clear what impact health care reform will have on health care services, especially those provided by allied health occupations. The moratorium should include petitions presented to the Commissioner for review of an occupation and legislative proposals for regulation. The moratorium should apply to occupations not currently regulated and those currently regulated occupations seeking changes in type of credential or administrative arrangement. A time-limited moratorium will allow the accumulation and analysis of information gathered from health care reform sources and from Department and health-related Licensing Board efforts. A three year period, beginning in fiscal year 1996 and ending in fiscal year 1999 will allow sufficient time to obtain the necessary information without unduly burdening the affected occupations.

RECOMMENDATION 2

During the period of the moratorium the Minnesota Department of Health and the health-related licensing boards shall address issues of health care quality, cost, access and government administration. Reports, proposed legislation and recommendations based upon their findings shall be submitted to the legislature by January, 1999.

The moratorium is predicated upon the lack of information for decision making about occupational regulation. The moratorium provides an opportunity for credentialing agencies to collect information regarding the impact of occupational regulation on the quality, cost and access to health care services. During this same time frame, administrative issues can also be studied in a period of relative stability for occupational regulation. Information collected shall be analyzed and submitted to the legislature along with any recommendations or proposals for legislative action that develop as a result of the information collected.

Implementation of the specific recommendations which follow may be compromised by anticipated reductions in funding of health planning and data collections activities. The Department and health-related licensing boards may need to prioritize and delay performance of some recommendations because of cost or unavailability of personnel.

QUALITY - RECOMMENDATION 1

In FY 1997, develop and submit legislation expanding the use of a temporary suspension clause to all of the current practice acts and develop uniform guidelines clarifying application of the clause.

It is recommended that the use of a temporary suspension clause be expanded to all practice acts. This will provide credentialing agencies with another means of disciplining practitioners who are practicing incompetently or unsafely. It allows agencies to act immediately in situations where a practitioner poses a threat of imminent or serious harm to the public if allowed to continue to practice. Development of uniform guidelines for application of the temporary suspension clause is also recommended to assure consistent public protection for all health care services provided by regulated practitioners. Each practice act will need either legislative amendment or rule amendment according to the basis for the practice act. An alternative may be to amend Minnesota Statutes, Chapter 214 to provide authority to all health-related licensing boards and other credentialing agencies to utilize temporary suspension as a means of public health protection.

QUALITY - RECOMMENDATION 2

In FY 1997, develop and submit legislation expanding the use of the reporting clause and companion immunity clauses to all regulated occupations and develop uniform guidelines for its application.

Expansion of the reporting clause to all practice acts is recommended to improve the quality assurance function of credentialing agencies. This requirement has been shown to increase the number of complaints filed with licensing boards regarding incompetent or unprofessional practice. Companion immunity clauses are needed to safeguard those who act in accordance with the reporting requirements and encourage compliance with the reporting requirements. The development of guidelines for application of reporting requirements will assure consistency among the credentialing agencies.

QUALITY - RECOMMENDATION 3

In FY 1996, develop and submit legislation seeking authority for and funding to provide for the receipt, compiling, referral and investigation of complaints against unregulated health and human service providers. The legislation should define illegal conduct and provide for powers and sanctions similar to those available to the Health Department for the regulation of unlicensed mental health service practitioners.

As discussed above, not all providers of health care are regulated by the various practice acts. Authority to receive and investigate complaints against unregulated individuals would provide a complaint resolution forum for consumers where one does not currently exist. As with the unlicensed mental health practitioners act, the prohibited acts should be defined in statute without regard to the type or amount of training that an individual has received. Authority over providers and sanctions for errant providers must also be identified

to enable the regulatory agency to effectively act upon consumer complaints. This legislation is aimed at reaching those individuals performing unsafe or unprofessional practices but who are not technically in violation of any particular practice act.

QUALITY - RECOMMENDATION 4

In FY 1996, begin discussion for identifying core competencies for areas of practice that regulated as well as unregulated providers would have to meet before they could practice in a particular specialty area. Report findings to the legislature in FY 1999.

This recommendation attempts to strengthen the quality assurance role through the identification of activity that needs monitoring rather than regulating individuals. This discussion should involve all credentialing agencies that regulate health-related occupations since the activities identified as core competencies could cross over the protected activities of several practice acts. This recommendation attempts to change the focus of occupational regulation and will require careful consideration of its impact on current health care delivery systems before implementation.

COST - RECOMMENDATION 1

Collect and analyze information on the annual rate of change in costs of regulating each health-related occupation for each of the three years of the moratorium. Report findings to the legislature in January, 1999.

As discussed above, it is apparent that there is a lack of accurate and complete information regarding the cost of occupational regulation. The moratorium will allow credentialing agencies to identify and collect necessary information in an environment where occupational regulations remain relatively constant. The information collected should provide the legislature with a more accurate picture of the cost of occupational regulation in Minnesota, forming the basis for subsequent legislative action regarding occupational regulation. It will provide a record over a period of time within which any trends in spending can also be identified.

COST - RECOMMENDATION 2

In FY 1998, begin to study financial alternatives to fee supported regulatory systems that would allow credentialing agencies to better weather fluctuations in regulatory costs due to rulemaking and disciplinary proceedings. Report results to the legislature by January, 1999.

Current requirements that credentialing systems be fee supported by the practitioners who are regulated limit the flexibility of the credentialing agency in responding to unexpected fluctuations in the cost of regulation. Any adjustments in fees to recoup losses due to changes in regulation or unexpectedly numerous or expensive disciplinary actions occur after the fact; often additional expenditure by the agency is required to obtain the needed fees adjustment. Financial alternatives should be explored which assure the accountability of the

credentialing agency while allowing flexibility for budget adjustments should unexpected expenses occur.

COST - RECOMMENDATION 3

In FY 1998, begin to study the feasibility and advisability of incorporating cost control measures into the practice acts. Report findings to the legislature by January, 1999.

Cost control measures for occupational regulation should focus not on the cost of services but on the general efficiency of the credentialing system as a whole. Theoretically, by managing costs of the credentialing system, costs to the consumer for services provided by the regulated practitioner are indirectly contained. Appropriate measures for managing costs of the credentialing system should be developed during the moratorium.

ACCESS - RECOMMENDATION 1

Establish a uniform procedure for responding to and recording consumer inquiries to credentialing agencies. Report the data collected from public inquiries about occupational regulation to the legislature by January, 1999.

This activity would involve the collection of data about how consumers use the occupational regulation systems and how well the systems serve their needs. There is currently no method for recording this information. It is important that all credentialing agencies deal with consumer calls from a consistent framework so that information collected is consistent and can be analyzed with some degree of accuracy. Reporting this data will allow the legislature to see the effects of occupational regulation and make informed decisions regarding any changes in regulatory systems which may be necessary.

ACCESS - RECOMMENDATION 2

In FY 1997, begin to study the feasibility/advisability of establishing a single access point for receipt of consumer complaints and providing consumer education regarding occupational regulation and report findings to the legislature.

With the changes in health care delivery brought about by health care reform efforts, there is concern that consumers may have difficulty identifying which entity to contact with complaints about health care services. Vertical integration of services blurs the lines of responsibility between providers. A single, easily identifiable resource for complaint filing and referral to appropriate credentialing agency may alleviate this anticipated problem. This same resource could also provide consumer education. Consumers would only need to know one contact number to receive the assistance they need or referral to the appropriate credentialing agency. The possibility of development of this type of resource should be reviewed along with its financial feasibility.

ACCESS - RECOMMENDATION 3

In FY 1996-1998, using information required for submission to the information clearinghouse, monitor the impact of health care reform on provider utilization (especially the allied health occupations), reimbursement patterns, and the cost of services and analyze the data to assess the impact of health care reform on occupational regulation.

Although there is presently a lack of information about the impact of occupational regulation, health care reform efforts establish several resources from which information about occupational credentialing may be obtained and subsequently analyzed. Consumer satisfaction surveys filed with the information clearinghouse may be used to identify any problem with health care services or providers. Health plan companies will be filing information which details the use of allied health professionals. The use of these sources, along with other information collected by the Department and health-related licensing boards should provide a basis for determining the effects of occupational regulation on health care delivery.

ADMINISTRATION - RECOMMENDATION 1

In FY 1998, develop a policy or rationale for determining the method of administration of a particular occupation and report to the legislature. Recommend to the legislature the criteria for determining the most appropriate organizational structure for administration of any new occupational groups or established groups seeking a change in administrative structure.

As discussed above, there is currently no rationale for determining the administrative structure for regulating a particular occupation. In the absence of criteria, occupations are assigned to any one of a variety of regulatory schemes. Definite criteria, based upon the characteristics of a particular occupational group and the services they perform would allow for more efficient operation of the entire regulatory system. The Department and the health-related licensing boards need to collaborate in examining how their organizations administer the various occupations to create a set of criteria for determining the most effective and efficient method of regulating occupations.

ADMINISTRATION - RECOMMENDATION 2

In FY 1998, recommend how credentialing agencies will be responsible for policy development and decisions regarding changes in regulatory standards and occupational scopes of practice.

Credentialing agencies are at times placed in a position of conflict when addressing policy issues which eventually impact upon their regulatory function. Policy decisions made by agencies in areas such as occupational regulation, scope of practice and practitioner discipline may be in conflict with current responsibilities under the credentialing system. Clear guidelines regarding the separate roles of policy-maker and regulatory agency would

allow the credentialing agencies to deal more efficiently and effectively with policy issues that arise.

ADMINISTRATION - RECOMMENDATION 3

In FY 1996, develop and submit legislation defining and establishing appropriate performance measures, such as outcome measures, output measures, efficiency measures and cost-effectiveness measures so that consistent data related to effectiveness of regulation can be reported by all entities responsible for occupational regulation. Recommend to the legislature any appropriate changes to performance measures for occupational regulatory activity.

Investigation into the types of performance measures and definition of outcomes in a manner similar to that used in the currently required performance reports would allow for the collection of more accurate and consistent information with which to assess the effects of occupational regulation. The current biennial board reports should be reviewed for any measures which yield the type of information needed. In addition, reporting of this information should be expanded to all credentialing activities within the Department of Health, not just the health-related licensing boards to obtain complete picture of occupational regulation in the state.

ADMINISTRATION - RECOMMENDATION 4

In FY 1997-1998, collect and analyze data from performance measures, such as outcome measures, output measures, efficiency measures and cost-effectiveness measures.

Once measures of occupational regulation have been determined, information should be collected by all credentialing agencies and analyzed to determine the impact of occupational regulation. These performance measures should enable the legislature to obtain a clearer picture of occupational regulation in Minnesota and will provide a basis for subsequent decisions regarding occupational regulation.

ADMINISTRATION - RECOMMENDATION 5

Recommend to the legislature whether the policy set forth in Minnesota Statutes, §214.001 should be revised for future evaluation of the need to regulate allied health occupations.

After obtaining the information from all of the resources described above, the Department and health-related licensing boards should be able to recommend to the legislature whether the current criteria and procedure for occupational reviews under Minnesota Statutes, Chapter 214 should be continued, discontinued or modified in any manner.

APPENDIX A

TABLE 1
UNREGULATED OCCUPATIONS

OCCUPATION	STATUS
Acupuncturists	Have sought certification or licensure annually since 1990.
Contact lens technicians	Affiliated with Opticians. See below.
Ear-piercing	
Electrologists	
Genetic counselors	Seeking licensure in 1995.
Homeopaths	
Hypnotherapists	
Laboratory technologists	Seeking licensure in 1995.
Massage therapists	Seeking licensure.
Medical assistants/ technologists	
Mental health counselors	
Naturopaths	
Opticians	Seeking licensure in 1995.
Phlebotomists	
Professional counselors	Seeking licensure in 1995.
Radiologic technologists	Sought certification in 1994.
Surgical assistants/ technologists	
Tattooists	

TABLE 2
OCCUPATIONS SEEKING REGULATORY CHANGE

OCCUPATION	STATUS
Audiologists	Seeking to replace registration with mandatory certification or licensure.
Dental Hygienists	Seeking a separate board.
Physician Assistants	Seeking transfer of regulatory authority from MDH to BMP.
Physical Therapists	Seeking separate board; licensure.
Speech-Language Pathologists	Seeking to replace registration with mandatory certification or licensure.

TABLE 3
OCCUPATIONS TO BE REGULATED

OCCUPATION	STATUS
Chemical Dependency Counselors	Licensed in 1993. Authority assigned to MDH in 1995. Rulemaking through 1995 for licensing in 1996.
Dietitians and Nutritionists	Licensed in 1994. Establishing an independent board.
Occupational Therapists	Rulemaking to register with MDH in 1995.
Traditional Midwives	Rulemaking to license with BMP in 1995.

APPENDIX B

TABLE 4

MODES OF REGULATION IN MINNESOTA
COMPARISON OF KEY ELEMENTS

MOST RESTRICTIVE:

LICENSURE

Functions Prescribed	Titles Restricted
Entry Reqs -Educ./Trng. -Practicum or Internship -Exam	Mandatory Continuing Education

Examples: Physicians, Nurses, Dentists, Social Workers, Psychologists

CERTIFICATION

Functions Prescribed	Titles Restricted
Entry Reqs. -Exam	May or May Not Have Continuing Education

Examples: Hearing Instrument Dispensers
Water Supply Operators

LESS RESTRICTIVE:

REGISTRATION

Functions Defined	Titles Restricted
Entry Reqs. -Educ./Trng. -Practicum Internship -Exam	Mandatory Continuing Education

Examples: Physical Therapists
Physician Assistants
Speech/Language Pathologists
Audiologists

PERMIT OR NONLICENSURE

Functions Defined Illegal Acts Enumerated	Any Title May Be Used
No Entry Requirements	No Continuing Education

Examples: Unlicensed Mental Health Counselors

TABLE 5
HEALTH-RELATED OCCUPATIONS - FORM OF REGULATION

	FORM OF REGULATION		
OCCUPATION	Licensure	Registration	Certification
Asbestos Contractor	X		
Athletic Trainers		X	
Audiologist		X	
Chiropractor	X		
Dentist	X		
Dental Hygienist	X		
Dental Assistant		X	
Emergency Medical Technician		X	
Hearing Instrument Seller			X
Home Care Provider		X	
Lead Abatement Contractor	X		
Lead Abatement Employee			X
Lead Inspector	X		
Marriage & Family Therapist	X		
Medical Doctor	X		
Mortician	X		
Nurse, Registered	X		
Nurse, Practical	X		
Nursing Home Administrator	X		
Optometrist	X		
Osteopath	X		
Pharmacist	X		
Physical Therapist		X	
Physician Assistant		X	
Plumber	X		
Podiatrist	X		
Psychologist	X		
Respiratory Care Practitioner		X	
Environmental Sanitarian		X	
Speech Language Pathologist		X	
Social Worker	X		
Water Conditioning (limited plumber)	X		
Water Well Contractor	X		
Water Supply Contractor			X

Licensure is defined in Minn. Stat. § 214.001 as "a system whereby a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing." (Title and scope of practice protection.)

Registration is defined in Minn. Stat. § 214.001 as "a system whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications." (Title protection only.)

APPENDIX C

TABLE 6
HEALTH-RELATED OCCUPATIONS - TOTAL DISBURSEMENTS*

Occupation	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
Asbestos Contractor	$ 175,933	$ 268,557	$419,240	$ 438,604	$ 441,369	$ 405,273
Chiropractor	$ 176,583	$ 279,383	$320,543	$ 306,171	$ 347,154	$ 397,188
Dentist Dental Hyg. Dental Asst.	$ 435,000	$ 564,000	$583,242	$ 731,218	$ 776,000	$ 919,000
Emer. Med. Technicians**	Not available	Not available	Not available	Not available	Not available	Not available
Environ. Hlth. Sanitarian	$ 5,145	$ 4,633	< $ 5,000	< $ 5,000	< $ 5,000	< $ 5,000
Hearing Inst. Dispenser	$ 5,145 (Rulemaking)	$ 58,620 (Start-up)	$ 94,995	$ 78,268	$ 103,921***	$ 188,267
Lead Abatement+					Not available	Not available
Marriage & Family Ther.	$ 71,285	$ 68,609	$ 83,931	$ 85,925	Not available	Not available
Medical Practice****	$1,413,000	$1,686,000	$2,443,525	$2,552,410	$2,659,000	$2,861,000
Mortician	$ 132,439	$ 144,950	$ 147,482	$ 136,920	$ 152,758	$ 165,706
Nurse+	$1,072,000	$1,232,000	$1,323,250	$1,484,253	$1,644,081	$1,876,923
Nursing Home Administrator	$ 156,000	$ 154,000	$ 168,000	$ 150,000	Not available	Not available
Optometrist	$ 55,000	$ 69,000	$ 74,000	$ 76,000	$ 75,000	$ 77,000
Pharmacist	$ 396,978	$ 459,826	$ 484,030	$ 543,998	$ 624,828	$ 616,774
Plumbers & Water Conditioner Operators	$ 345,366	$ 354,129	$ 387,605	$ 451,929	$ 471,207	$ 517,723
Podiatrist	$ 13,656	$ 22,007	$ 23,845	$ 22,940	$ 38,283	$ 43,348
Psychologist	$ 271,834	$ 327,169	Not available	Not available	Not available	Not available
Social Work	$ 125,312	$ 131,694	$ 189,306	$ 492,905	$ 500,000	$ 579,000
Speech-Lang. Pathologist/ Audiologist	$ 15,037 (Rulemaking)	$ 26,772 (Rulemaking)	$ 36,912 (Rulemaking)	$ 57,922	$ 68,322	$ 44,717
Water Supply Operator	$ 12,559	$ 13,322	$ 14,025	$ 14,607	$ 15,136	Not available
Water Well Contractor+++	$ 27,000	$ 532,293	$1,566,283	$1,766,956	$2,210,335	$1,966,286

* Not all health care occupations are individually listed in this table. Please see notes below.
** EMT category includes 3 levels of personnel; large number of personnel are volunteers.
*** A mandatory certification system was initiated in 1993.
**** The Board of Medical Practice licenses physicians and registers athletic trainers, physician assistants, physical therapists, and respiratory care practitioners. Expenditures for each separate occupation are not available.
+ The Minnesota Department of Health began licensing Lead Abatement Contractors and Lead Inspectors in 1993. Certification of Lead Abatement Employees also began in 1993.
++ The Board of Nursing licenses Registered Nurses and Licensed Practical Nurses.
+++ The Water Well Contractor Program became the Well Management Program in January, 1990. Fees were not set to recover cost prior to this change.
Sources: Department of Finance and Minnesota Department of Health, Financial Management