November 12, 2013

Sen. Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Building
Washington, DC 20510

Rep. Dave Camp
Chairman
House Ways & Means Committee
1100 Longworth Building
Washington, DC 20515

Sen. Orrin Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Building
Washington, DC 20510

Rep. Sandy Levin
Ranking Member
House Ways & Means Committee
1100 Longworth Building
Washington, DC 20515

VIA EMAIL: sgrcomments@finance.senate.gov, sgrwhitepaper@mail.house.gov

SUBJ: APRN Organizations Response to Bipartisan Bicameral SGR Repeal and Medicare Payment Reform Proposal

Dear Chairmen Baucus and Camp, and Ranking Members Hatch and Levin:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs), we express our support for continued legislative progress on a bipartisan, bicameral framework released Oct. 30, 2013, repealing the Medicare sustainable growth rate (SGR) formula and reforming Medicare Part B payment, and urge its continued improvement.

The APRN Workgroup is comprised of organizations representing Nurse Practitioners (NPs) delivering primary, specialized and community healthcare; Certified Registered Nurse Anesthetists (CRNAs) who provide the full range of anesthesia services as well as chronic pain management; Certified Nurse-Midwives (CNMs) expert in primary care, maternal and women's health; and Clinical Nurse Specialists (CNSs) offering acute, chronic, specialty and community healthcare services. Totaling more than 200,000 healthcare professionals, including two of the ten largest categories of Medicare Part B provider specialties according to Medicare claims data, our primary interests are patient wellness and improving patient access to safe and cost-effective healthcare services. In every setting and region, for every population particularly among the rural and medically underserved, America's growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost-effective healthcare delivery.

Advanced Practice Nursing Principles for Medicare Payment Reform

Thanks to the previous work of Congress, APRNs bill Part B and report on the Centers for Medicare & Medicaid Services' (CMS) Physician Quality Reporting System (PQRS) measures

as physicians do. However, numerous barriers to the contributions of APRNs exist in the current system, which Congress should address in payment reforms:

- First, **Congress should direct that registered nurses (RNs) and APRNs be made full partners in the development, use and evaluation of quality measures, including measures used for Medicare payment and incentives.** Clearly the same service provided by different providers or provider types should be held to the same standard.

- Second, **Congress should ensure that measures evaluate the work being done by the provider who is performing the service.** There should be no measures that reward physicians or other providers solely for the services RNs or APRNs lead and deliver.

- Third, **Congress should require that the infrastructure for quality reporting be accessible and transparent.** Currently, the services RNs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups' participation.

- Fourth, **Medicare payment reform legislation should ensure that the development and implementation of alternative payment systems such as Accountable Care Organizations (ACOs) and bundled payment involves and recognizes APRNs** in the same manner that physicians are recognized.

APRNs Support Repealing the SGR Formula and Reforming Medicare Payment

We join in expressing support for permanently repealing the flawed SGR funding formula that frequently threatens Medicare beneficiaries, providers and the Medicare program with unsustainable and draconian cuts. Replacing the SGR with a 10-year period of payment stability as Medicare payment systems transition to alternative payment models protects the Medicare program and provides an environment for developing, testing and implementing innovation. Though we are grateful for the proposal, we are concerned that level-funding Part B to current levels for the next 10 years does not keep up with healthcare costs and does not bring providers up to pre-sequestration funding levels. We also note that over the next ten years the Medicare population will increase by 20 million beneficiaries to 72 million. Nevertheless, we commend lawmakers from both chambers of Congress for their bipartisan collaboration yielding a common proposal, giving us hope that Congress can enact reforms before 24 percent SGR cuts to Part B take place Jan. 1, 2014. We look forward to continuing work with you on legislation that stabilizes Medicare payment and promotes innovations that increase quality and access and help control healthcare cost growth.

As you know, RNs in general and APRNs in particular provide crucial care to patients in every environment that healthcare is delivered, contribute to community health and healthcare delivery for populations, and engage in leadership activities necessary that promote patient access to better healthcare and cost savings to the healthcare system in the United States. The care our members provide includes services billed directly to Part B, services bundled into hospital or other facility claims, services billed "incident-to" the services of a physician and reported by the physician not the APRN providing the care, and population and community healthcare. **Thus, as the Committee develops legislation to repeal the SGR formula and reform the Medicare payment system, we ask on behalf of the patients for whom we provide care that you keep this in mind: Nurses will always put patients first.**

In *The Future of Nursing: Leading Change, Advancing Health*, **the Institute of Medicine's (IOM) first recommendation is for APRNs to practice to the fullest scope of their education and training, and its third is to expand opportunities for RNs and APRNs to develop and exercise leadership in redesigning healthcare in the United States. The IOM recommends policymakers eliminate barriers to the fullest and best use of APRNs, not only so that they can practice to the fullest extent of their license but also to provide for the growing number of Medicare beneficiaries and other patients' access to high quality, cost-effective care.** This action is a crucial imperative at every level of healthcare policy from Congress and the Administration, to states, to healthcare facilities and private enterprise, and in every part of our country, particularly rural and medically underserved America which rely heavily on APRN care. Failure to make the highest and best use of APRNs by protecting unnecessary and costly guild-driven barriers to their care denies patient access to quality care, limits healthcare improvement, and wastes taxpayer and private resources.

APRN Recommendations for the Bipartisan Bicameral SGR Repeal and Medicare Reform Proposal

Our specific observations on and recommendations to the bipartisan bicameral proposal are as follows:

- **The development, evaluation and implementation of quality measures and standard of care guidelines must be made provider-neutral.** The first page of the bipartisan bicameral proposal speaks to "physician-developed" quality indicators and standards of care payment codes. We urge you to include all Part B providers in the development of new payment codes, as well as in the utilization of these standards of care. Likewise, we encourage you to utilize already developed National Quality Forum (NQF) and AQA quality indicators in the development of quality measures as discussed on the third page of the proposal. These indicators have already been vetted for provider neutrality and have been accepted as quality indicators by the health care community. If quality indicators outside the realm of the NQF and AQA indicators are necessary, then all provider groups should be included in their development as well as utilization. Several of our organizations are members of the NQF and have participated in the American Medical Association Physician Quality Performance Improvement (AMA PCPI)

program, the development of hospital Surgical Care Improvement Project (SCIP) measures, the evaluation and refinement of Patient Safety Indicators (PSI) of the Agency for Healthcare Research and Quality (AHRQ), and other initiatives. Thanks to the previous work of Congress, APRNs billing Part B report on the CMS PQRS measures as physicians do. **Congress should insist that quality measures and care guidelines driving Medicare payment and incentives be "evidence-based" and consensus driven, not "physician-developed."**

- **We note that the proposal leaves room for additional provisions supported by members of the committees of jurisdiction, and have specific recommendations about such provisions affecting the care delivered by APRNs.** These include the following measures that have been referred to House and Senate healthcare committees of jurisdiction:

    - **We have significant concerns about a proposal to expand Medicare rural anesthesia pass-through programs to also cover the services of anesthesiologists.** In rural America, CRNAs provide anesthesia services safely and comprehensively, and ensure patient access to care. However, a proposal to expand the Medicare reasonable-cost pass-through program for CRNA services to also cover the services of anesthesiologists raises substantial concerns. Anesthesiologist labor costs are approximately three times those of CRNAs; Medicare should not pay three times more for the same high quality service. The legislation apparently leaves room for Medicare coverage of "medical direction" and remote "supervision" services, both of which add to healthcare costs without improving access or quality, and neither of which add "boots on the ground" anesthesia services into rural America. Instead, **Congress should restore Medicare Part A coverage of CRNA rural on-call services** that help ensure rural patient access to care as originally envisioned by the pass-through program.

    - We recommend that the committees take steps to **remove barriers to care provided by APRNs under both Medicare Parts A and B.** These barriers include the authorization of home health services and hospice services by APRNs, admitting patients to skilled nursing facilities, authorization of rehabilitation services, supervision of cardiac and pulmonary rehabilitation services and the inclusion of primary care patients under an APRN's care in the Medicare Shared Savings Program. Further concerns about "incident to" provisions currently in Medicare law are addressed below in more detail. Such barriers to the full use of APRNs create unnecessary costs to the Medicare program that could be reduced by their reform or repeal.

    - **APRNs are failing to be appropriately reimbursed under the Medicare program for the time they spend training residents. We ask the Committee to consider remedying this concern by amending the Medicare statute to incorporate the role of APRNs in supervising services provided by a resident.** The existing Medicare statute is silent on the status of APRNs who train residents

in teaching facilities, while specifically allowing physicians to be reimbursed for the time they spend training residents under Medicare Part B. Special payment rules detail how teaching facilities can be reimbursed for a physician's time supervising and instructing interns and residents in teaching facilities. These payments are authorized under section 1861(b) of the Social Security Act [42 U.S.C. 1395x(b)]. The law and existing regulations are silent, however, on whether APRNs should be reimbursed in these same teaching facilities. Thus, teaching facilities are not able to bill the Medicare program for the time these professionals spend training interns and residents. Officials at the Centers for Medicare and Medicaid Services have said that a statutory modification would need to be made for the agency to pursue rules to allow payment to teaching facilities for such services. The Accreditation Council of Graduate Medical Education's (ACGME) Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, effective as of January 2008, highlight for example the roles of certified nurse-midwives and nurse practitioners supervising residents in part VI.D of the document. It states, "In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. Any health professional with appropriate certification, e.g., Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, can be listed as faculty (page 25)." We ask the Committee to consider remedying this concern by amending the Medicare statute to reference the role of APRNs in supervising services provided by a resident.

- **We are concerned that the proposal phases-in eligibility for value-based payment systems and incentives and delays implementation for APRNs. Congress should implement Medicare payment reforms and quality measures for incentives for APRNs in the same way that such reforms and incentives are authorized for physicians.** Phased implementation in this manner picks winners and losers in the marketplace by legislative fiat, and poses complications for facilities, practices and groups where multiple provider types bill the Medicare program. One example of such discriminatory policy already in law is the Affordable Care Act provision authorizing increased Part B physician payments of 0.5 percent through CY 2014 only for those medical doctors who have completed a "maintenance of certification" (MOC) program. APRNs developing and carrying out similar MOC programs are ineligible for this increase, intended to promote advanced lifelong competency development among healthcare professionals. To the extent that this MOC program is continued, it should treat APRNs the same as physicians.

- **Clinical performance improvement activities should relate to the full range of care provided to patients by all types of healthcare providers including APRNs.** The proposal appears chiefly focused on primary care clinical performance improvement activities. Our organizations are committed to clinical improvement activities and support innovative efforts to provide high quality, cost-effective access to healthcare.

Our contributions within the realms of quality, access and cost effectiveness include evidence-based practice standards, transition to competency-based recertification for practice, and support of the practice doctorate for clinically-based practitioners. While clinical improvement activities are what practitioners will employ to improve their quality measures, we do not believe they should be mandated for use in payment systems. We believe the emphasis should be on improvement and results. The development of clinical practice improvement activities is an ongoing endeavor. Crucially, quality measures and standards of care apply to all healthcare professionals; there is not one high standard of care when one professional type provides a service and another standard when another professional type provides the same service. Identifying, developing and validating additional evidence-based clinical practice improvement activities may require years to develop and implement. It should be noted that clinical practice improvement initiatives at the facility level, when developed by the interprofessional team, can be planned, implemented and evaluated for ongoing improvement in a much more collaborative and timely manner.

- **Provisions offering Medicare payment incentives for meaningful use and other participation in electronic health records (EHR) and other health information technology (HIT), and penalties for failing to report such use, should exempt provider types that have been ineligible for Hi-Tech Act incentives for acquiring EHR systems.** The legislative authorization providing incentives for EHR use, as well as its regulatory implementation, exempt APRNs from funding under Medicaid, Medicare, or both. Such APRNs should not be subject to Medicare payment penalties for not using HIT for which they were ineligible for federal funding to acquire and implement.

- **We would like to thank the committee for allowing nurse practitioners, clinical nurse specialists and physician assistants to be eligible for reimbursement for the complex chronic care management services they provide.** We would also request that the committees ensure that this payment is available to all APRNs who treat patients in physician-centered medical homes (PCMHs) or comparable specialty practices providing complex chronic care services. Doing so will ensure that chronically ill patients whose primary health care providers are APRNs are not denied Medicare coverage for the care coordination services that peer-reviewed evidence links to improvements in health and cost savings.

- **We recommend that the legislation authorize Medicare coverage of service ordered by APRNs acting within their scope of practice in the same fashion that Medicare covers services ordered by physicians.**

- **To the extent that the legislation encourages reforms to and public use of the Physician Compare site**, we want the Committee to be aware that this site does not recognize APRNs acting within their scope of practice in the same way that it recognizes physicians. The site's name and search features hinder individuals from finding APRNs and other qualified healthcare professionals who are not physicians. For example, when

the page asks, "What are you searching for?" the option is "Doctor Last Name or Specialty or Medical Condition." Congress should be aware that APRNs are a common type of provider used by Medicare patients. Of the top ten categories of Medicare providers by specialty type, Medicare claims data shows that two of those ten are categories of APRNs. We request that Congress direct CMS to apply accurate and provider-neutral language throughout the site, including the site's title, menus and options.

- We appreciate the Committees' effort to address the need for greater transparency in Medicare utilization and payment data. **As the program moves toward a payment structure based on the quality and value of the services provided to beneficiaries, Medicare must have clear and accurate information on which to assess the performance of providers. However, Medicare's current policies on "incident-to" billing of services directly contradict that goal, obscuring the provider actually accountable for services delivered to patients.** For billing and payment purposes, Medicare policy currently treats "incident-to" services as if the billing practitioner actually furnished them; the true provider of care is almost totally obscured. The inability to clearly identify the practitioner who provides the care is an obvious obstacle to accurately measuring the quality of care and assessing the value of innovative practice structures. **We believe that the practice of "incident to" billing should be eliminated and that qualified providers should be required to bill directly for the services they personally provide under their own provider numbers.** As services commonly furnished in physicians' offices and other non-facility settings have expanded to include more complex procedures, the types of services that can be furnished "incident-to" physicians' services have also expanded. These complicated services go beyond Medicare's policy that "incident-to" services comprise "an integral, although incidental part of the physician's professional services." Accountability for more complex services should require that the performing clinician be clearly identified if that person is not the billing provider. **As an important and achievable first step, we urge you to require that any services being billed "incident to" the services of a physician clearly identify the clinician performing the service.** In an August 2009 report, "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services" (OEI-09-06-00430), the Department of Health and Human Services Office of Inspector General recommended that CMS "require physicians who bill services to Medicare that they do not personally perform to identify the services on their Medicare claims by using a service code modifier." The Inspector General points out that requiring the use of a modifier would allow CMS to monitor claims to ensure that physicians are billing for services performed by providers with appropriate qualifications. We believe the use of a modifier would also allow Medicare to hold the actual provider of a service accountable for the quality and value of the services provided and reduce confusion and inaccuracies in assessing performance on quality measures. We believe that there should be modifiers for all practitioners delivering the service, including Advanced Practice Registered Nurses, who are certified nurse anesthetists, nurse practitioners, clinical nurse specialist and certified nurse midwives.

- **A final recommendation to the Committee is to complete the payment revolution began in 1992 with the conversion to the Resource Based Relative Value System (RBRVS) method of determining Medicare approved charges. The remaining differentials in Medicare allowances for services from NPs and CNSs should be eliminated.** Medicare once tolerated differentials by specialty or experience in the form of the customary and prevailing reasonable charge determination method. The physician community agreed to renounce that approach when it acquiesced to the introduction of RBRVS. A novice family practitioner gets the same allowance as an experienced neurosurgeon in a level 3 initial office visit. The allowance for all physicians in a given Medicare locality is the same if it is billed as the same service. Medicare Part B provides coverage of CRNA and CNM services at 100 percent of the Medicare Fee Schedule (MFS) because they are qualified providers that provide the same service that a physician would provide in submitting similar claims. The same services provided by NPs or CNSs only get paid 85 percent of the MFS amounts. This defies the RBRVS logic. **A service ought to be paid as a service, regardless of the eligible professional providing that service. Princeton Professor of Economics Uwe Reinhardt, PhD, testified before the Senate HELP Subcommittee on Primary Health and Aging in January 2013 that the differential between Medicare physician and Medicare NP and CNS payment had no justification. He also noted that the Medicare Payment Advisory Commission (MedPAC) could not find a theoretical foundation for the existing payment differentials for identical primary care services rendered by primary care physicians and by non-physician primary care givers. Dr. Reinhardt called for eliminating these differentials in public insurance programs and for private health insurers as well.** Elimination of the differential is well overdue.

We thank you for your attention to these issues as you continue working to permanently repeal the Medicare SGR formula and reform Medicare payment, and to develop provisions to fund these provisions. We look forward to continue keeping members of Congress informed about the interests and concerns of hundreds of thousands of APRNs and the millions of patients for whom they provide care all across America. If you have questions, please contact Frank Purcell of the American Association of Nurse Anesthetists, 202-741-9080, fpurcell@aanadc.com, and thank you.

Sincerely,

American Academy of Nursing, AAN

American Association of Colleges of Nursing, AACN

American Association of Nurse Anesthetists, AANA

American Association of Nurse Practitioners, AANP

American College of Nurse-Midwives, ACNM

American Nurses Association, ANA

National Association of Clinical Nurse Specialists, NACNS

National Association of Nurse Practitioners in Women's Health, NPWH

National Association of Pediatric Nurse Practitioners, NAPNAP

National Organization of Nurse Practitioner Faculties, NONPF

Cc: Members of the House Ways & Means and Senate Finance Committees