

July 17, 2013

Honorable Marilyn Tavenner, MHA, RN
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-9957-P, Mail Stop C4-26-05,
7500 Security Boulevard
Baltimore, MD 21244-1850

Sent via email to: <http://www.regulations.gov>

Re: Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards. 78 Fed Reg. 37032 (June 19, 2013)

Dear Administrator Tavenner:

The American Nurses Association (ANA) welcomes the opportunity to provide comments on this proposed rule. As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, ANA is privileged to represent its state and constituent member associations, organizational affiliates, and individual members. As you are no doubt aware, RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members also include advanced practice registered nurses (APRNs) such as nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs).

As detailed below, ANA urges the Agency to support patient care through the adoption of a modest prospective approach to network adequacy standards with respect to advanced practice registered nurses rather than a retrospective decertification approach as proposed in §156.810(a)(8). The proposed rule would allow a Qualified Health Plan (QHP) to be decertified if the QHP issuer substantially fails to meet the requirements under §156.230 related to network adequacy standards or, §156.235 related to inclusion of essential community providers.

Despite numerous recent reports that enthusiastically recommend the elimination of both (a) States' scope of practice barriers with respect to advanced practice registered nurses and (b) traditional private health insurer practices that prohibit APRN participation in private health insurance networks, evidence remains that APRNs continue to be excluded from private health insurance networks, thus exacerbating patient and prospective exchange client challenges in access to primary care health services. Medicare Part B, on the other hand, clearly identifies each of the four APRN roles for provision of clinical services to Part B beneficiaries. As a result, in 2011, CMS data indicate that 100,585 APRNs billing under their own NPIs provided services worth \$2.4 billion in approved charges to 10.4 million Medicare fee-for-service beneficiaries. Those 100,585 APRNs also represent a primary source of women entrepreneurs in health care. Further, those 10.4 million patients represent 30% of the national total of Medicare fee-for-service beneficiaries. Comparable data on APRN participants in Medicare Part B are available for each of the 50 States and the District of Columbia. The percentage of fee-for-service patients who received APRN services ranged from 7.2% in Hawaii to as high as 58.0% in Tennessee. (A copy of the 2011 CMS data is attached.)

Rather than an expensive and long drawn out process for eliminating QHPs that have failed to meet network adequacy standards, ANA proposes a simpler prospective qualification. Any health plan that wants to become a QHP in a particular State should be required to demonstrate that it has credentialed a number of APRNs that is no less than 10% of the most recent Medicare Part B APRN count for that State. The applications of candidate organizations that do not meet this criterion will be deferred until and unless they demonstrate the requisite number of APRNs in the network they propose for the relevant Exchange.

Background

ANA notes that in October 2010 after two years of hearings and deliberations and with the support of the Robert Wood Johnson Foundation, the Institute of Medicine published The Future of Nursing: Leading Change, Advancing Health.¹ This has been the most frequently downloaded IOM report virtually every month since its initial publication. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. Those recommendations were intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care. A specific recommendation in the Report was to require third-party payers that participate in fee-for-service payment arrangements to provide direct reimbursement to advanced practice registered nurses who are practicing within their scope of practice under state law.

A systematic review of advanced practice registered nurse (APRN) patient outcomes compared with those of physicians and other health care teams without APRNs was published in the September/October 2011 issue of Nursing Economics.² In this systematic review, Robin P. Newhouse, PhD, RN, NEA-BC, and co-authors compare APRN processes and outcomes to those of physician providers. Sixty-nine studies published between 1990 and 2008 were analyzed and 28 outcomes were summarized for nurses practicing in APRN roles. The results indicated that APRNs provide safe, effective, quality care and play a significant role in promoting health and health care. The review concludes that the results "could help address concerns about whether care provided by APRNs can safely augment the physician supply to support reform efforts aimed at expanding access to care."

In December 2012, The National Governors Association (NGA) Center for Best Practices undertook a review of the literature and State rules governing NPs' scope of practice to consider their potential role in meeting the increasing demand for primary care.³ The NGA's research suggested that NPs can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients. To better meet the nation's current and growing need for primary care providers, NGA recommended that States consider easing their scope of practice restrictions and modifying their reimbursement policies to encourage greater NP involvement in the provision of primary care.

Despite the documentation of high quality services (and high patient satisfaction therewith) there is considerable evidence that private health insurers have ignored if not distained inclusion of APRNs

¹ Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health. Washington, DC: National Academies Press, 2010.

² Newhouse RP, Stanik-Hutt J, White KM, Johantgen M, Bass EB, Zangaro G, Wilson RF, Fountain L, Steinwachs DM, Heindel L, Weiner JP, "Advanced practice nurse outcomes 1990-2008: a systematic review," Nursing Economics, 2011 Sep-Oct;29(5):230-50.

³ National Governors Association, The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care, 2012.

into private health insurance networks. Tine Hansen-Turton and colleagues from the National Nursing Centers Consortium have conducted repeated studies of the credentialing behavior of private health insurers. They reported managed care organization (MCO) credentialing rates for NPs of 33% in 2005⁴ and 53% in 2007⁵. A more recent survey in this series focused on the credentialing policies of health maintenance organizations (HMOs) within managed care organizations during 2011-2012.⁶ Sixty-seven percent of HMOs with significant commercial product lines credentialed NPs as primary care providers. Those HMOs with significant Medicare or Medicaid product lines exhibits higher credentialing rates of 76% and 83%, respectively. This might be considered an improvement were it not for the fact that NP services are by law included in the benefit packages of both of those programs. That one sixth to one quarter of these private plans could not comply with Medicare and/or Medicaid credentialing requirements suggests the need for more explicit rules of qualification.

Proposed Change

The proposed rule would allow a QHP to be decertified if the QHP issuer substantially fails to meet the requirements under §156.230 related to network adequacy standards or, §156.235 related to inclusion of essential community providers. The entirety of Subpart J of the rule is devoted to implementation of QHP issuer sanctions, presented on all or parts of five pages of the rule. Given that the network adequacy language adopted in the Affordable Care Act is not exactly definitive, a great deal of time and money could be occupied with litigation in this regard. ANA proposes a simpler pre-qualifying standard that would obviate much of the need for time and money in litigation.

As stated above, in 2011 CMS data indicate that 100,585 APRNs billing under their own NPIs provided services worth \$2.4 billion in approved charges to 10.4 million Medicare fee-for-service beneficiaries. These are data with respect to National & State Level Physician/Supplier Counts and Beneficiaries Served, derived from CMS administrative claims data, January 2009-December 2011, accessed from the Chronic Condition Warehouse (CCW). These data were supplied to ANA by the Centers for Medicare and Medicaid Services, Office of Information Products and Data Analysis. Medicare has traditionally collected annual counts of physicians and suppliers by specialty since the beginning of the program in the late 1960s. State by State counts of the total number of APRNs engaged in calendar year 2011 as Medicare Part B providers have been included at the end of this document. These counts range from a low of 156 APRNs in Hawaii to a high of 6535 in Florida.

ANA's proposal is quite modest. Given that the IOM has demonstrated the potential of APRNs to alleviate potential shortages of physician services, particularly with respect to primary care; that considerable research exists documenting the good patient outcomes with respect to patients treated by APRNs; the stated interest of the National Governors' Association in expanding access to NPs; and the lackluster efforts of many private insurers to secure and offer these important clinician services, it is incumbent on those running the State Exchanges to verify that potential offerers have secured such access to APRN services prior to being authorized as Qualified Health Plans. In particular, no plan should be accepted that has not credentialed in its proposed State Exchange

⁴ Hansen-Turton T, Ritter A, Begun H, Berkowitz SL, Rothman N, Valdez B. Insurers' contracting policies on nurse practitioners as primary care providers: The current landscape and what needs to change. *Policy Polit Nurs Pract* 2006;7:216-226.

⁵ Hansen-Turton T, Ritter A, Torgan R. Insurers' contracting policies on nurse practitioners as primary care providers: Two years later. *Policy Polit Nurs Pract* 2008;9:241-248.

⁶ Tine Hansen-Turton, JD, MGA, FCPP, FAAN, Jamie Ware, JD, MSW, Lisa Bond, PhD, Natalie Doria, BN, JD, RN, CHC, and Patrick Cunningham, "Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices," Population Health Management, forthcoming.

networks a number of APRNs that is no less than 10% of the number of independently practicing APRNs enrolled as Medicare Part B providers who have provided one or more services to Medicare fee-for-service beneficiaries in the most recent year for which CMS provider data are available. The applications of candidate organizations that do not meet this criterion will be deferred until and unless they demonstrate the requisite number of APRNs in the network they propose for the relevant Exchange.

APRN enrollment as a Part B provider requires procurement of an individual National Provider Identifier (NPI) and vetting by the relevant Medicare Part B carrier of the attainment of proper educational standards required by Medicare. Thus the candidate QHP meets those educational requirements and has the identifying information required for electronic payments. When the Affordable Care Act was passed, there were 152,000 APRNs who had procured an individual NPI representing all four APRN roles in each of the 50 States and DC. In all likelihood, there are now 200,000 APRNs that could be available to be credentialed in networks proposed for the Exchanges whether or not they currently are enrolled in Medicare Part B.

This is a standard that is easy to understand, easy to police, and easy to meet for those candidate QHPs that are serious about addressing the issue of potential strains on patient access to primary care services. ANA believes the proposed change is worth serious consideration and quick adoption.

We appreciate the opportunity to share our views on this matter. We would be happy to speak with HHS and/or CMS leadership and staff further. Please feel free to contact Peter McMenamin, PhD, Senior Policy Fellow, ANA Nursing Practice and Policy, at peter.mcmenamin@ana.org, or (301) 628-5073.

Sincerely,

A handwritten signature in black ink that reads "Marla J. Weston". The signature is written in a cursive, flowing style.

Marla J. Weston, PhD, RN, FAAN
Chief Executive Officer
American Nurses Association

cc: Karen A. Daley, PhD, MPH, RN, FAAN
President
American Nurses Association

2011 CMS State Level Medicare Part B Provider Counts of APRNs

<i>Total</i>	100,585	<i>MISSOURI</i>	2,996
<i>DISTRICT OF COLUMBIA</i>	429	<i>MONTANA</i>	412
<i>ALABAMA</i>	2,034	<i>NEBRASKA</i>	843
<i>ALASKA</i>	362	<i>NEVADA</i>	344
<i>ARIZONA</i>	1,751	<i>NEW HAMPSHIRE</i>	836
<i>ARKANSAS</i>	979	<i>NEW JERSEY</i>	1,996
<i>CALIFORNIA</i>	2,865	<i>NEW MEXICO</i>	842
<i>COLORADO</i>	1,257	<i>NEW YORK</i>	4,902
<i>CONNECTICUT</i>	1,771	<i>NORTH CAROLINA</i>	4,222
<i>DELAWARE</i>	311	<i>NORTH DAKOTA</i>	592
<i>FLORIDA</i>	6,535	<i>OHIO</i>	4,827
<i>GEORGIA</i>	2,890	<i>OKLAHOMA</i>	947
<i>HAWAII</i>	156	<i>OREGON</i>	1,275
<i>IDAHO</i>	642	<i>PENNSYLVANIA</i>	5,503
<i>ILLINOIS</i>	3,233	<i>RHODE ISLAND</i>	471
<i>INDIANA</i>	2,265	<i>SOUTH CAROLINA</i>	1,799
<i>IOWA</i>	1,219	<i>SOUTH DAKOTA</i>	560
<i>KANSAS</i>	1,592	<i>TENNESSEE</i>	4,479
<i>KENTUCKY</i>	2,618	<i>TEXAS</i>	6,189
<i>LOUISIANA</i>	2,160	<i>UTAH</i>	635
<i>MAINE</i>	979	<i>VERMONT</i>	310
<i>MARYLAND</i>	1,802	<i>VIRGINIA</i>	2,624
<i>MASSACHUSETTS</i>	3,815	<i>WASHINGTON</i>	2,373
<i>MICHIGAN</i>	3,808	<i>WEST VIRGINIA</i>	938
<i>MINNESOTA</i>	3,461	<i>WISCONSIN</i>	2,615
<i>MISSISSIPPI</i>	1,778	<i>WYOMING</i>	204

Source:

National & State Level Physician/Supplier Counts and Beneficiaries Served derived from CMS administrative claims data, January 2009 - December 2011, accessed from the Chronic Condition Warehouse (CCW). These data were supplied to ANA by the Centers for Medicare and Medicaid Services, Office of Information Products and Data Analysis.