

# Medicare Payment for Registered Nurse Services and Care Coordination

**Effective Date:** 2017

## I. Summary

This paper summarizes how Medicare pays for the services of Registered Nurses under its various payment systems. Next, the paper reviews Medicare payment for patient care coordination and how these care coordination programs can or may compensate nursing services. Finally, the paper addresses various proposals that could be adopted either legislatively or through regulation that could provide better access or more favorable payment for nursing services. The discussion will include payment for Advanced Practice Nurses (APRNs) including Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Registered Nurses (RNs and other degree-credentialed nurses).

As will be seen throughout all but the last section of the paper, Medicare can pay APRNs directly for furnishing services to Medicare beneficiaries (although at a percentage of the rate paid to physicians for NPs and CNSs), but there is no provision in the law that allows Medicare to make direct payment to other types of nurses such as RNs. The last section of the paper will describe the arguments for and against paying NPs and CNSs at the same rate as physicians as well as changes in policy that could be made either under the Centers for Medicare & Medicaid Services' administrative authority or through changes in statute for consistency in how NPs and CNSs are treated under Medicare payment policy. Finally, the paper will provide a discussion of the likely obstacles to achieving direct Medicare payment for RNs' services, how those obstacles may have been overcome in other circumstances, and suggestions for future work the American Nurses Association (ANA) can do to further achieve this goal.

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## II. How Does Medicare Decide What Services to Pay For?

Medicare Part A provides benefits for inpatient hospital care, skilled nursing facility care, home health, and hospice. Medicare Part B provides benefits for physician and other practitioner services, diagnostic services, outpatient hospital services, durable medical equipment, and ambulance services, among others. Medicare Parts A and B are known as original Medicare and generally pay using a fee-for-service model. Medicare beneficiaries can opt to receive their Medicare benefits through Medicare Part C, which means they have elected to have their Medicare Parts A and B benefits furnished through a private insurer. A private insurer may use fee-for-service or capitation as its model for paying for Part A and Part B services on behalf of its enrolled beneficiaries.

Within Parts A and B of Medicare are “benefit categories” that allow Medicare to make payment for specific services. Medicare is a defined benefit category program. This means that Medicare can pay for any service that is described by a benefit category in Title XVIII of the Social Security Act (the Act). For example, “physicians’ services” is a benefit category that allows Medicare to pay for the services of physicians. As will be explained in more detail below, there are also specific benefit categories for APRNs that allow APRNs to receive direct payment from Medicare. Other than the specific APRNs with a distinct benefit category, there is no benefit category that allows Medicare to pay other nurses directly for the services they provide. Nursing services will usually be encompassed by a more broadly described benefit category that allows Medicare to compensate the nurse’s employer for the nursing services being provided. Some common benefit categories under which Medicare will pay for nursing services are described below.

**Physicians’ Services:** Section 1861(s)(1) of the Act is the benefit category for physicians’ services. The statute defines physicians’ services as “professional services performed by physicians...,” which means anything a physician does that meets the criteria for Medicare coverage—meaning, is “reasonable and necessary” for the treatment of illness or injury—is a physician’s service. As is described in more detail below, Medicare will pay for the services of nurses working for the physician under the “incident to a physician’s service” benefit category.

**Inpatient Hospital Services:** Section 1861(b) of the Act defines “inpatient hospital services” as including “such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients...” This language is part of a larger definition that includes bed and board among other services. As is common in the description of a benefit category, the statute indicates that Medicare’s payment for inpatient hospital services includes a broad range of services that are typically provided by hospitals. In the case of inpatient hospital services, Medicare’s payment will be made directly to the hospital because it is the hospital that is incurring the costs for the set of services described by the “inpatient hospital services” benefit category.

Section 1861(b) of the Act explicitly excludes some practitioner services that have their own benefit categories from the definition of inpatient hospital services—specifically the services of physicians, APRNs (NPs, CNSs, CNMs and CRNAs), and qualified psychologists. These practitioner services can be independently billed to Medicare and will be paid in addition to Medicare’s inpatient hospital payment. If these practitioners are employed by hospitals, their services remain separately billable to Medicare although employed practitioners typically reassign their billing privileges to their employer hospital that bills for their services.

**Skilled Nursing Facility (SNF) Services:** Sections 1861(h) and (i) of the Act provide Medicare with the authority to pay for SNF services (called “extended care services” in the statute). To be eligible for SNF services, the Medicare beneficiary is required by the statute to have been treated as a hospital inpatient for at least 3 consecutive days. The law defines SNF services as “items and services furnished to an inpatient of

a skilled nursing facility” including “nursing care provided by or under the supervision of a registered professional nurse.” In the case of SNF services, the statute allows Medicare’s payment to the SNF to include the service of an RN or of a nurse with a lower level of certification who is working under the supervision of an RN. Again, this definition is a partial one and the definition of SNF services will include a broader list of services such as bed and board, physical and occupational therapy services, and speech–language pathology among other services. Payment for the comprehensive list of SNF services defined by the statute, including those provided by nurses, is made to the SNF itself. SNF services also do not include practitioner services such as those furnished by APRNs, which can be separately billed in addition to Medicare’s payment to the SNF.

**Home Health Services:** Section 1861(m) of the Act defines the term “home health services” as including “items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with...such agency.” Among those services included in “home health services” are “part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.” Again, this definition is a partial one and the definition of home health services will include a broader list of services such as physical and occupational therapy services and medical social services, among others. The home health services definition of nursing services is very similar to the how nursing services are described for the SNF benefit category, with the major difference being that the nursing services can be “part-time or intermittent.” However, they must be furnished under the supervision of an RN. Payment will be made directly to the home health agency for all services it provides that are included in the home health services benefit category. Practitioner services are not commonly furnished in a patient’s home although if provided, they have their own benefit category and would be paid separately by Medicare using the home visit codes.

**NP and CNS Services:** Section 1861(s)(2)(K)(ii) of the Act provides Medicare with authority to make payment directly to NPs and CNSs. Specifically, the statute defines these services as:

...services which would be physicians’ services...if furnished by a physician...which are performed by a nurse practitioner or clinical nurse specialist...working in collaboration... with a physician...which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed...

This benefit category is constructed such that Medicare payment can be made to NPs and CNSs directly for any service that would be covered if it were furnished by a physician. The benefit category for physicians is unlimited. Any service performed by a physician would be included in the physicians’ services benefit category (section 1861(s)(1)) and would be paid by Medicare, provided the service is reasonable and necessary. Unlike benefit categories for certain other practitioners, for NP and CNS services the Medicare statute limits payment only to the extent that the service is within the NP’s or CNS’s state scope of practice.<sup>1</sup>

Section 1861(s)(2)(K)(i) provides Medicare with authority to make payment directly to physician assistants (PAs). The PA benefit category is constructed in the same way as the NP and CNS benefit category—it is unlimited and would include any service that has a benefit category that would be paid for by Medicare if it were done by a physician.

One important distinction among PAs, NPs, and CNSs in the Medicare statute is that the Medicare benefit category requires the NP or CNS to be working “in collaboration” with a physician as a condition of payment rather than “under the supervision of a physician,” which is required for PAs. “Collaboration” is a less restrictive standard than “supervision.”<sup>2</sup> Unlike NPs and CNSs who may be completely in independent

<sup>1</sup> For example, the Medicare statute limits the services of Clinical Social Workers (CSW) to the “diagnosis and treatment of mental illnesses,” which precludes Medicare from paying CSWs for any services that do not have a psychiatric basis of origin. The statute further precludes direct payment to a CSW for services provided to inpatients of hospitals and SNFs. Compensation for CSW services for hospital and SNF inpatients is made directly to the hospital or SNF.

<sup>2</sup> Supervision is “direct,” “general,” or “personal.” “Direct supervision” means that the physician or other practitioner must be

practice and enrolled in Medicare, the PA supervision requirement precludes PAs from being enrolled in Medicare with 100% ownership of their own practices. The statute and regulations further prescribe the educational and other qualifications that an NP and CNS must meet in order to bill Medicare directly for furnishing services.

**Certified Nurse-Midwife (CNM) Services:** Section 1861(s)(2)(L) of the Act furnishes the authority for Medicare to pay for CNM services. Like NP and CNS services, the CNM service benefit category allows Medicare to pay for any CNM services within the CNM’s state scope of practice that would otherwise be covered if furnished by a physician.

**Certified Registered Nurse Anesthetist (CRNA) Services:** Section 1861(s)(11) of the Act furnishes the authority to pay for CRNA services. The CRNA benefit category allows Medicare to pay for “anesthesia services and related care” rather than “services which would be physicians’ services if furnished by a physician.” Because the statutory language for the CRNA benefit category is different from that for NPs, CNSs, and CNMs, a question arose in 2012 as to the meaning of “anesthesia services and related care” and whether Medicare can make payment only for CRNA services related to surgical anesthesia. The Medicare program is administered by Medicare Administrative Contractors (MAC) who process claims and make decisions locally about whether to cover and pay for individual services. The decision to clarify the meaning of “anesthesia services and related care” was initiated because a MAC medical director decided that Medicare is prohibited by statute from paying for CRNA interventional pain management services unrelated to surgical anesthesia.

In the calendar year 2013 physician fee schedule final rule, CMS indicated that “[a]nesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.”<sup>3</sup> This statement would appear to make the CRNA benefit category as expansive as the NP, CNS, and CNM benefit categories. At this time, we are unaware of any MAC making decisions to limit the CRNA benefit category to specific services. It is possible that a MAC could potentially make a local coverage determination that limits services a CRNA could do and be paid by Medicare. To do that, the MAC would have to justify specifically why it is not reasonable and necessary for a CRNA to provide a particular service that is covered when it is done by a physician, provided the service is within the CRNA’s state scope of practice.

**Rural Health Clinic (RHC) Services and Federally Qualified Health Center (FQHC) Services:** Section 1861(s)(2)(E) of the Act authorizes Medicare to pay for RHC and FQHC services. RHCs and FQHCs have a special designation under the Medicare statute and meet specific criteria. Among other benefit categories, the RHC and FQHC benefit category is composed of physicians’ services, “incident to” services (described below), and the benefit categories for PAs and NPs (not CNSs), clinical psychologists, and clinical social workers. FQHCs are also paid for specific preventive and screening services. Practitioner services are paid directly to the RHC or FQHC.

**“Incident to” Services:** The “incident to” services benefit category is a very complex provision of the Medicare statute that allows Medicare to pay for a wide variety of different services, including nursing

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immediately available (although not in the room or within any physical boundary of the property) to furnish assistance and direction throughout the performance of the procedure. “General supervision” means the procedure or service is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. “Personal” supervision means a physician must be in attendance in the room during the performance of the procedure. “Collaboration” is a process in which an NP or CNS works with one or more physicians (MD or DO) to deliver healthcare services, with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. In the absence of state law governing collaboration, collaboration is to be evidenced by NPs and CNSs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP or CNS when the services are furnished or to make an independent evaluation of each patient who is seen by the NP or CNS.

<sup>3</sup> Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule. 77 FR 68891 (16 November 2012), p. 69009

services, either directly to a physician when services are provided in a physician's office or to a hospital when services are provided in the hospital outpatient department. The "incident to" provisions are likely the most common way that Medicare pays for the large majority of nursing services provided by nurses who are not APRNs in a physician's office or a hospital outpatient department. Section 1861(s)(2)(A) states that Medicare may cover:

services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills...

Section 1861(s)(2)(A) is the "incident to" a physician's service benefit category for services provided in a physician's office. It is the basis upon which Medicare makes an explicit payment for some services under Medicare Part B ("drugs and biologicals which are not usually self-administered by the patient"), while other services are implicitly compensated through Medicare's payment to the physician—services such as those of a nurse or other staff employed by and working under the supervision of a physician. The "incident to" benefit category is only for therapeutic services. Medicare may pay for diagnostic services, such as electrocardiograms, laboratory tests, and X-rays under other benefit categories. There are also separate benefit categories for influenza, pneumococcal, and hepatitis B vaccines and their administration—all services that may involve nurses. The "incident to" benefit category would, in general, be for services that are not described by other benefit categories. The distinction between a service furnished under "incident to" benefit category or another benefit category will be relevant to whether the supervision rules or other rules specific to the benefit category apply.<sup>4</sup>

Any therapeutic services furnished in a physician's office under the "incident to" benefit category must be furnished under the direct supervision of the physician or a nonphysician practitioner such as an NP or CNS. (Below the paper refers to all services as being "incident to" a physician's service because that is how the statutory benefit category reads. However, because Medicare policy allows the "incident to" provision to apply to services incident to an NP, CNS, or CNM service, when the service is referred to as being "incident to" a physician's service, the paper includes these additional practitioners collectively as APRNs in a "physician's service.")

"Incident to" a physician service means that the patient has or will be seeing the physician or APRN and the related service being provided by the nurse or other staff person is a result of being "incident to" the physician service. For instance, one of the most common services that a physician or APRN will provide to a Medicare patient in an office is an office visit. The service of the physician or APRN him or herself would be an 1861(s)(1) "physicians' service" or the relevant benefit category for each APRN that has independent billing privileges. The practitioner's practice expense, including the costs of nursing services provided as part of the office visit, would be considered "incident to" the physician's or APRN's professional service and a cost that is "commonly either rendered without charge or included in the physicians' bills."

Another common scenario is that the physician or APRN will order services for the patient that requires the patient to make a return trip to the office to receive those services but does not need to see the physician or APRN and will be treated by a nurse. These services are considered "incident to" a physician's service because the services were ordered by the physician or APRN during the current or a prior encounter. Although the physician or APRN may not see the patient when the patient is receiving these services, Medicare will pay the physician or APRN directly for the services of the nurse and any related costs because the physician or APRN incurs these expenses. Common services provided in this way include chemotherapy

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<sup>4</sup> The relevance of the benefit category is critical here. If the nurse is providing services under a benefit category other than "incident to" (diagnostic test, for instance), the supervision requirement may be personal (the physician has to be in the room while the service is being performed), direct, or general. For other benefit categories (influenza vaccines and their administration, for instance), there is no supervision requirement.

or injection services for which the physician or APRN may be paid directly for the drug administration service, including the cost of the nurse.

While Medicare will make payment to the physician or APRN for drug administration costs such as the nurse, medical supplies, and other costs through a single payment, the drug or biological will be paid separately under the “incident to” benefit category. Specific provisions in the statute define drugs and biologicals and specify how they are paid under Medicare Part B when furnished “incident to” a physician’s services in a physician office.<sup>5</sup>

Section 1861(s)(2)(B) states that Medicare may cover:

hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians’ services rendered to outpatients and partial hospitalization services incident to such services.

Section 1861(s)(2)(B) is the “incident to” a physician’s service benefit category for services provided in the hospital outpatient department. It parallels the “incident to” a physician’s service benefit category for services provided in a physician’s office, except that payment is made to the hospital and not the physician. Further, the nurse and other staff involved in furnishing the service are now employed by the hospital, not the physician. However, the nurse and other staff continue to be required to work under the supervision of a physician or APRN.

Take the instance of a visit that occurs in the hospital outpatient department. In this case, the direct interaction between the physician or APRN and the patient would be considered an 1861(s)(1) physician’s service or the relevant benefit category for each APRN that has independent billing privileges. The cost of the nurse and other related costs of the visit are incurred by the hospital and would be compensated under the 1861(s)(2)(B) “incident to” benefit category for hospital outpatient services. Medicare’s payment to the physician or APRN will be lower and exclude these direct patient care costs being incurred by the hospital for which there will be a payment to the hospital for their institutional costs, including the cost of nursing services.

In the instance of chemotherapy or injection services ordered by the physician but that occur in the hospital outpatient department, these services are 1861(s)(2)(B) hospital outpatient services that are “incident to” a physician or APRN service but provided completely by the hospital. Therefore, there is only a payment to the hospital for its institutional costs (including the cost of nursing) services and no payment is made to the physician or APRN who had no involvement in the service other than it being under his or her supervision.<sup>6</sup>

### III. How Does Medicare Decide How to Pay for Services in the Different Benefit Categories?

The first step in deciding whether Medicare can pay for an item or service is determining whether the service has a benefit category. The first section of this paper outlined common benefit categories that include the services of nurses or describe services for which Medicare can pay APRNs directly. The second

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<sup>5</sup> Only drugs “not usually self-administered by the patient” will be paid under Medicare Part B. Drugs that are usually self-administered by the patient will be paid under Medicare Part D.

<sup>6</sup> Nearly all hospital services furnished under the “incident to” benefit are required to be provided under direct supervision. A small minority of services may be provided under general supervision. Hospitals often own physician practices that may be part of, or “provider-based” to, the hospital even though they are not on the hospital campus. The hospital outpatient department supervision rules apply in this situation, not the rules that apply in a physician’s office. The Bipartisan Budget Act of 2015 does not allow payment under the outpatient prospective payment system on or after January 1, 2017, for new off-campus provider-based departments that opened after November 2, 2015, with very limited exceptions for sites where construction was planned as of that date.

step in determining whether Medicare can pay for an item or service is deciding whether the service is “reasonable and necessary for treatment of illness or injury.” Once it is determined that an item or service has a benefit category and that it is reasonable and necessary, the last step before making payment is deciding how the service is to be paid. This section of the paper describes the statutory basis and methodologies that Medicare uses to pay for services described by the above benefit categories.

**Inpatient Hospital Services:** Section 1886 of the Act includes provisions that specify how inpatient hospital services are paid. Most general acute care hospitals are paid under section 1886(d) of the Act using the hospital inpatient prospective payment system (IPPS). Medicare’s IPPS payment is a single payment to the hospital for all services provided from admission to discharge as well as preadmission services provided by the hospital on the day of admission or the 3 calendar days prior to admission. Payment for all nursing services provided by the hospital will be included in Medicare’s IPPS payment. The IPPS payment does not include compensation for practitioner services, such as those of NPs, CNSs, CNMs, and CRNAs. These services are paid directly to these practitioners under the Medicare physician fee schedule (MPFS) described below.

**SNF Services:** SNF services are also paid under a prospective payment system (PPS). Unlike the IPPS, which provides a single bundled payment for all services provided by the hospital, the SNF PPS is a per diem system that includes payment to the SNF for all costs of furnishing covered Part A SNF services (routine, ancillary, and capital-related costs). Nursing services provided to a patient during a Part A SNF stay will be included in Medicare’s SNF PPS payment. Like the IPPS, the SNF PPS does not include payment for practitioner services. The services of NPs, CNSs, CNMs, and CRNAs can be paid directly to these practitioners practicing in a SNF above and beyond the SNF PPS amount. One complexity of payment to SNFs is that the Medicare patient may exhaust Medicare Part A SNF benefits during an SNF stay. In this case, Medicare Part B will make payment to the SNF for a limited list of medically necessary ancillary services. Nursing services are considered routine services, not ancillary services. Therefore, Medicare’s payment under Part B to a SNF when the patient exhausts Part A SNF benefits will not include payment for nursing services except to the extent they are included in Medicare’s Part B payment.

**Home Health Services:** Medicare makes a PPS payment to a home health agency for a 60-day episode of home health services that will include all nursing and therapy services, routine and nonroutine medical supplies, and home health aide and medical social services. Like the SNF and IPPS payment, the home health PPS does not include payment for practitioner services such as NP and CNS services, which can be billed separately when provided to a Medicare beneficiary who is in a home health episode of care.

**NP, CNS, and CNM Services:**<sup>7</sup> Medicare makes payment for NP, CNS, and CNM services based on the MPFS. The MPFS is a fee schedule with an individual payment amount for as many as 8,000 different procedure codes. Section 1833(a)(1)(O) of the Act requires NPs and CNSs to be paid 85% of what Medicare would pay a physician for the same service or 85% of the MPFS payment amount. Until January 1, 2011, CNMs were paid 65% of the MPFS payment amount. Beginning January 1, 2011, Medicare allows CNMs to be paid 100% of the MPFS amount. The final section of this paper will posit arguments for changing the statute so that all APRNs are paid at 100% of the MPFS.

**CRNAs:** CRNAs are paid 100% of the MPFS when they are paid directly for practitioner services, for example when they provide nonanesthesia services such as interventional pain management services outside of the hospital. Anesthesia services are paid under a special anesthesia fee schedule that considers the time of the

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<sup>7</sup> In 2017, CMS implemented the Quality Payment Program, which includes the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models that can provide bonuses or penalties to physicians and practitioners that furnish Part B services. The MIPS program comprises four categories: quality, cost, improvement activities, and advancing care information. NPs, CNSs, and CNRAs are subject to MIPS if they bill more than \$30,000 to Medicare and provide care for more than 100 patients per year.



surgical procedure for which the anesthesia services are being furnished. CRNAs may be paid directly under the anesthesia fee schedule when they personally perform anesthesia services and are separately enrolled and billing directly. At other times, payment for the CRNA's service may be made directly to a hospital or anesthesiologist that employs them. Often CRNAs furnish services under the medical direction of an anesthesiologist. In this case, the anesthesiologist is paid directly for the anesthesia service under special rules that consider how many concurrent procedures are occurring. When the CRNA is working under the medical direction of an anesthesiologist, the CRNA may be employed or under contract to a physician or a hospital and Medicare is not making direct payment to the CRNA.

**RHC and FQHC Services:** Medicare pays the RHC 80% of its reasonable costs subject to a per-visit limit—an all-inclusive rate limit that equals \$80.32 for 2017. FQHCs are paid under the FQHC PPS, which is also a single all-inclusive rate that averages \$163.49 per visit in 2017. Each encounter in an RHC or FQHC with an eligible practitioner such as a physician, NP, or PA will generate a billable visit that allows direct payment to the RHC or FQHC instead of the practitioner.

**“Incident to” Services:** Medicare will pay for the services of employed nurses under the “incident to” provision using the payment system for the site where the service is furnished—the MPFS when the service is furnished in a physician's office and the outpatient prospective payment system (OPPS) when the service is provided in the outpatient department of a hospital. (CMS views “employed” as meaning either a W-2 direct employee or a 1099 contract employee.) Nursing services other than those with a separate benefit category (NPs, CNSs, CNMs, and CRNAs) can only be paid under the “incident to” benefit to the nurse's employer.

Nursing services furnished by NPs and CNSs in physician offices can be furnished either directly under their own benefit category or under the “incident to” benefit category when the NP or CNS is employed by the physician practice that bills for their services. Under the “incident to” benefit, the NP and CNS service will be paid at 100% of the MPFS because the claim is coming from the physician practice, not the NP or CNS. When paid directly under the NP or CNS benefit category, the service will be paid at 85% of the MPFS amount. There is no “incident to” billing under the MPFS in the hospital outpatient department so the services of NPs and CNSs can only be paid separately and in addition to the OPPS payment to the hospital under the NP and CNS benefit category at 85% of the MPFS amount.

## IV. Medicare Care Coordination Initiatives

CMS has a number of care coordination initiatives currently under way. This paper divides those initiatives into:

1. Those that are part of the current Medicare fee-for-service program and are in place under current provisions of Medicare law and regulations; and
2. Models or experiments for which the Center for Medicare and Medicaid Innovation (CMMI) has authority under section 3021 of the Affordable Care Act to waive current provisions of law and regulations.

### A. Care Coordination Provisions of the Current Fee-For-Service Program in Place Nationally

**Transitional Care Management (TCM):** TCM services are services provided to a Medicare beneficiary in the 30 days following a discharge from a hospital or SNF to assist in the beneficiary's transition to the community setting. The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the service.

Medicare began paying for TCM services in 2013. TCM includes compensation for direct face-to-face services and non-face-to-face services provided by a physician, NP, CNS, or CNM, or staff working under the supervision of these practitioners through the “incident to” benefit category. The required face-to-face visit must be furnished under at least direct supervision. TCM set a precedent in the Medicare fee-for-service program by explicitly recognizing and compensating for the costs of non-face-to-face services in furnishing a service. Further, the non-face-to-face portion of the service may be provided under general supervision—the first time that Medicare is permitting supervision for a therapeutic service under the “incident to” benefit at a supervision level other than direct. General supervision may provide the opportunity for nurses to provide care coordination services for the non-face-to-face services included in TCM either through care management companies under contract to physicians or directly under contract to physicians. Medicare pays for TCM under CPT codes 99495 and 99496.

**Chronic Care Management (CCM):** Beginning in 2015, Medicare began providing separate payment for CCM services under CPT code 99490, for at least 20 minutes per calendar month of clinical staff time directed by a physician or other qualified health professional (which would include APRNs) that requires:

1. The patient to have two or more chronic conditions expected to last at least 12 months, or until the death of the patient;
2. Chronic conditions that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline; and
3. The physician or APRN to establish, revise, or monitor a comprehensive care plan.

Beginning January 1, 2017, Medicare began providing payment for complex CCM services under CPT code 99487 that require the above elements as well as:

1. Moderate- or high-complexity medical decision-making; and
2. 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Patient consent is required for non-face-to-face services such as CCM. CCM and complex CCM services set a precedent in the Medicare fee-for-service program by allowing Medicare to pay for a service that does not require a face-to-face encounter with a physician or APRN. Further, clinical staff providing CCM or complex CCM services must be under the general supervision of a physician or an APRN. Allowing for general supervision for a non-face-to-face service will allow clinical staff coordination activities to be furnished remotely from where the physician or APRN is practicing, which opens up the possibility for physicians and APRNs to contract for nursing and other services to fulfill the clinical staff care coordination portion of the service.

**Psychiatric Collaborative Care Model (CoCM):** Beginning January 1, 2017, Medicare began paying for psychiatric CoCM under codes G0502–G0504.<sup>8</sup> Psychiatric CoCM typically is provided by a primary care team consisting of a primary care practitioner and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

The CoCM model provides potential opportunities for nurse involvement in care coordination. The physician fee schedule final rule specifically indicates “the behavioral health care manager may or may not be a

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<sup>8</sup> The CY 2017 physician fee schedule final rule indicates that the descriptors for these codes are copyrighted to the American Medical Association and will be the same as the codes that will be in the 2018 CPT book.

professional who meets all the requirements to independently furnish and report services to Medicare.” In response to a public comment, CMS further notes:

nurse practitioners who furnish the psychiatric CoCM services as described may bill for the psychiatric CoCM codes. Nurse practitioners who meet our final qualifications to serve as the behavioral health care manager may provide the behavioral health care manager services incident to the services of another (billing) practitioner. Nurse practitioners who meet all of our final requirements to serve as the psychiatric consultant may provide the psychiatric consultant services incident to the services of the billing practitioner.<sup>9</sup>

This response specifically addressed a comment about whether NPs may bill for CoCM. The rule otherwise makes clear that any qualified practitioner with a Medicare benefit category (e.g., a CNS qualified to furnish this service) may bill Medicare for CoCM.

CMS is assigning general supervision to the psychiatric CoCM codes, indicating that it is not clinically necessary for the billing practitioner to be immediately available to the behavioral health care manager and the psychiatric consultant at all times as would be required under direct supervision. Like CCM, general supervision provides opportunities for physicians and APRNs to contract for nursing care coordination services that may be provided remotely from the physician or APRN that is billing for CoCM. G0502–G0504 are respectively for: 1) initial CoCM care, first 70 minutes per month; 2) subsequent CoCM care, first 70 minutes per month; and 3) each additional 30 minutes of COCM care.

**General Behavioral Health Integration (BHI):** General BHI describes care management services for patients with psychiatric conditions where the specific elements of the CoCM model may not be met. Beginning January 1, 2017, Medicare began paying for general BHI services under code G0507. G0507 is for patients that have identified psychiatric or behavioral health conditions that require a behavioral health care assessment, behavioral health care planning, and provision of interventions. The care management services require at least 20 minutes of clinical staff time, directed by a physician or other qualified healthcare professional, per calendar month. The final rule indicates that the clinical staff services may be provided under the “incident to” rules under general supervision and the staff do not have to be employed by the treating practitioner or located on site and may or may not be professionals who are permitted to independently furnish and report services to Medicare. Clinical staff may provide the services under the general supervision of the billing practitioner. The final rule further notes that G0507 is valued to include minimal work by the treating practitioner; the bulk of the valuation is based on clinical staff time. However, the clinical staff providing services must have a collaborative, integrated relationship with the treating practitioner. They must also have a continuous relationship with the beneficiary.

Because this service is generally done by clinical staff without direct Medicare billing privileges and may be done under general supervision, it would appear to provide opportunities for nurse care managers to be employed by or under contract with physicians to provide care coordination services to patients requiring BHI services.

**Assessment and Care Planning for Patients with Cognitive Impairment:** Beginning January 1, 2017, Medicare began paying for assessment and care planning for patients with cognitive impairment such as Alzheimer’s disease under code G0505 (AMA has developed a corresponding CPT code that is expected to be part of CPT for 2018). G0505 is for the work of a physician or APRN for assessing and creating a care plan for beneficiaries with cognitive impairment, such as Alzheimer’s disease or dementia, at any stage of impairment. CMS specifies the elements that the practitioner must furnish to bill for this code on the CY 2017 physician fee schedule final rule.<sup>10</sup> While this service is designed to recognize the work of the physician

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<sup>9</sup> Most of the text in this section is taken directly from the CY 2017 Physician Fee Schedule Final Rule published in the *Federal Register* on November 15, 2016, pages 80230-80236.

<sup>10</sup> Medicare Program: CY 2017 Physician Fee Schedule Final Rule. 81 FR 80170 (15 November 2016), p. 80252.

or APRN, the final rule indicates that “outside of the specified elements, the regular incident-to rules apply consistent with other E/M [evaluation and management] services.”<sup>11</sup> Thus, to the extent that nurses working under the direct supervision of a physician or APRN are providing supportive care coordination services to the practitioner providing assessment and care planning for patients with cognitive impairment, Medicare may compensate the practitioner for these services under the “incident to” benefit category.

**Accountable Care Organizations (ACO):** ACOs are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. Participation in an ACO creates incentives for healthcare providers to work together to treat an individual patient across care settings—including doctor’s offices, hospitals, and long-term care facilities. ACOs must serve at least 5,000 Medicare fee-for-service patients, meet all other eligibility and program requirements, and agree to participate in the program for at least 3 years.

Medicare continues to pay individual ACO providers and suppliers for covered items and services as it currently does under conventional fee-for-service payment systems. CMS also develops a benchmark for each ACO against which ACO performance is measured to assess whether the ACO generated savings or losses for the Medicare program during a performance year. ACOs that meet or exceed a minimum savings rate, satisfy minimum quality performance standards, and otherwise maintain their eligibility to participate in the Medicare Shared Savings Program are eligible to receive a portion of the savings they generate (“shared savings”). In addition, if an ACO has chosen to operate under a two-sided risk model, and it meets or exceeds a minimum loss rate, it must repay a portion of the losses it generates (“shared losses”).

Beneficiaries may be assigned to an ACO if they receive most of their primary care services from an ACO participant, although beneficiaries may elect not to have services attributed to and coordinated by an ACO. Even if beneficiaries elect to have their services attributed and coordinated by an ACO, they may continue to receive services from healthcare providers outside of the ACO. With a beneficiary’s permission, the ACO may request and receive beneficiary claims data to assist the ACO in understanding beneficiary utilization of medical services and in coordinating the beneficiary’s future care. To determine the assignment of a beneficiary to an ACO, CMS uses the beneficiary’s primary care services performed by primary care physicians as well as NP, CNSs, and PAs.

Like other care coordination initiatives under way in Medicare, there may be a role for nurses in care coordination and management to the extent that an ACO sets up an explicit care management infrastructure. There are no specific provisions that address the role of nurses in care coordination or the “incident to” provisions of the law and regulations. Therefore, to the extent that nurses are furnishing care coordination services under the “incident to” provisions, the services would have to be under direct supervision of a physician or an APRN. However, an ACO may be free to provide care coordination services for which none of its members are seeking direct payment. To the extent that those care coordination services are not separately billable to Medicare, no condition-of-payment supervision requirement would have to be met. The care coordinator would not be required to be under direct or general supervision.

## **B. Care Coordination Models Under Study by the Center for Medicare and Medicaid Innovation**

**Comprehensive Primary Care Initiative (CPCI):** CPCI was a four-year multipayer initiative designed to strengthen primary care. The initiative tested whether population-based care management fees and shared savings opportunities supported by multiple payers could achieve improved care, better health for populations, and lower costs. The program began in 2012 and ended in 2016. The monthly payment from Medicare averaged \$20 per beneficiary per month during years 1–2 of the initiative (2013–14), and decreased to an average of \$15 per beneficiary per month during years 3–4 (2015–16). Practices also

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<sup>11</sup> Medicare Program: CY 2017 Physician Fee Schedule Final Rule. 81 FR 80170 (15 November 2016), p. 80253.

received monthly fees from other participating CPCI payers and were expected to combine CPCI revenues across payers to develop a whole-practice transformation strategy. CPCI was limited to practices in Arkansas, Colorado, New Jersey, Oregon, and parts of New York, Ohio, Kentucky, and Oklahoma.

Although CMS indicated that NP practices could participate in CPCI, no NP practices were selected for the demonstration. CMS indicated that practices have the discretion to use enhanced nonvisit compensation to support “care teams (e.g. case managers, social workers, health educators, pharmacists, nutritionists, behavioralists) embedded in the practice.” Further, CMS indicated the monthly per-patient per-month fee can be used to support “community health teams.”<sup>12</sup> In its first year, CPC achieved gross savings and was nearly cost-neutral, with positive quality results. See below for discussion of CPC+, which looks to build on the results of CPCI by offering two tracks with different payment options to better accommodate the diverse needs of primary care practices.

Again, as with CCM and complex CCM, CPCI provided an opportunity for the involvement of nurses in care coordination. Indeed, Mathematica Policy Research indicated in its third-year evaluation of the program that “care managers, who are predominantly nurses, tended to focus on patient education, coaching, and monitoring for chronic conditions, management of care transitions, post-discharge contact, and care plan development.”<sup>13</sup> The Mathematica report further indicates that nurses were used as on-call staff to triage patient issues after hours and address patient needs by telephone.<sup>14</sup> CMS indicated there would be a separate review of the contribution of APRNs to the effectiveness of practices involved in CPCI but aside from measures of APRN participation, no analyses of the relative effectiveness of various configurations of APRNs so involved were reported.

**Comprehensive Primary Care (CPC) +:** CPC+ is a five-year model that will be in place from 2017 through 2021. Like CPCI, the program is multipayer. CPC+ is designed to transform primary care practices and build capabilities and care processes to deliver better care. Participation in CPC+ is voluntary and open to practices in the same areas that were eligible to participate in CPCI plus Hawaii, Michigan, Montana, all of Ohio, all of Oklahoma, Rhode Island, Tennessee, and the Greater Philadelphia Region.

CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee for Medicare fee-for-service patients attributed to their practice (patients are attributed to a practice if that practice is where they receive the plurality of their primary care services). In addition, CMS will prospectively pay a performance-based incentive payment, which practices may keep if they meet annual performance thresholds. CMS will provide larger performance-based incentive payments in Track 2 than in Track 1. All practices that do not meet the annual thresholds would be required to repay all or a portion of the prepaid amount. CPC+ may not bill for CCM for patients attributed to their practice.

Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination. Track 1 practices will receive a care management fee that averages \$15 per beneficiary per month (PBPM) to support their transformation efforts. Track 2 practices will receive an average of approximately \$28 PBPM.

In Track 1, practices will also continue to receive regular Medicare fee-for-service payments for covered evaluation and management services. In Track 2, CMS is introducing a hybrid of fee-for-service and Comprehensive Primary Care Payment (CPCP). This hybrid payment will pay for covered evaluation and management (E&M) services, but allows flexibility for the care to be delivered both in and outside of an

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<sup>12</sup> Centers for Medicare & Medicaid Services. (2012). *Webinar: The comprehensive primary care initiative for primary care practitioners*, slide 23. Retrieved from <https://innovation.cms.gov/resources/CPCI-Webinar-for-PCPs.html>

<sup>13</sup> Mathematica Policy Research. (2016). *Evaluation of the comprehensive primary care initiative: Third annual report*, p. 74. Princeton, NJ: Author. Retrieved from <https://innovation.cms.gov/Files/reports/cpci-evalrpt3.pdf>

<sup>14</sup> Mathematica Policy Research. (2016). *Evaluation of the comprehensive primary care initiative: Third annual report*, p. 100. Princeton, NJ: Author. Retrieved from <https://innovation.cms.gov/Files/reports/cpci-evalrpt3.pdf>

office visit. Track 2 practices will receive a percentage of their expected Medicare E&M payment up front in the form of a CPCP and a reduced fee-for-service payment for face-to-face E&M claims.

Eligible applicants are primary care practices that provide health services to a minimum of 150 attributed Medicare beneficiaries. “Primary care practitioner” includes physicians, NPs, and CNSs with primary specialty designation of family medicine, internal medicine, or geriatric medicine. There would appear to be significant opportunities for NPs and CNSs to be directly eligible for care coordination payments under CPC+. Care management fees and performance-based incentive payments may also indirectly support the activities of other nurses in the practice transformation and other activities to improve quality and lower costs for patients in needs of multiple services.

**Oncology Care Model (OCM):** Under OCM, practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. CMS is also partnering with commercial payers in the model. The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries such as care coordination, navigation, and national treatment guidelines for care. OCM provides an incentive to participating practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience or health outcomes. Like CPCI, OCM practices receive a monthly payment (\$160 per beneficiary) and the opportunity for performance-based incentives based on lowering the total cost of care and improving quality. OCM focuses on Medicare FFS beneficiaries receiving chemotherapy treatment and includes the spectrum of care provided to a patient during a 6-month episode that begins with chemotherapy. OCM is a 5-year model that began on July 1, 2016, and runs through June 30, 2021. Participants in OCM cannot also bill for CoCM services.

The \$160 per beneficiary per month fee is not a payment for a service and therefore can be used to support care coordination activities that are not subject to Medicare’s supervision rules. Thus, nurses could potentially receive direct payment under a contract to an oncology practice for performing care coordination activities. OCM includes care coordination activities that are well suited to the skills of nurses. CMS indicates that these care coordination activities may include:

- Coordinating appointments with providers within and outside the oncology practice to ensure timely delivery of diagnostic and treatment services;
- Providing 24/7 access to care when needed;
- Arranging for diagnostic scans and follow-up with other members of the medical team such as surgeons, radiation oncologists, and other specialists that support the beneficiary through his or her cancer treatment;
- Making sure that data from scans, blood test results, and other tests are received in advance of patient appointments so that patients do not need to schedule additional visits; and
- Providing access to additional patient resources, such as emotional support groups, pain management services, and clinical trials.

**Bundled Payment for Care Initiative (BPCI):** The BPCI initiative is composed of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. Model 1 ran for 3 years and ended on December 31, 2016. Models 2–4 continue to be active. The models are voluntary and allow participants to select among one of 48 different types of clinical episodes.

Models 2 and 3 are retrospective payment models in which Medicare continues to make regular fee-for-service payments that are then compared against the target price so Medicare can determine a payment or recoupment amount reflecting the aggregate expenditures compared to the target price.

In model 2, the episode includes the inpatient stay in an acute care hospital plus the postacute care and all related services up to 90 days after hospital discharge. In model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of postacute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency.

In model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment.

BPCI establishes the basic model by which other episode-bundling projects are constructed such as the Comprehensive Care for Joint Replacement model that will be discussed next. The major differences between BPCI and the care coordination initiatives described to this point are that the prior models are practitioner-based and include a specific payment for care coordination. BPCI does not include a specific payment for care coordination and is for institution-based care (although model 4 includes physician payments). BPCI is focused on episode-based care coordination among hospitals, physicians, and postacute care providers (model 2), postacute providers and physicians (in model 3), and hospitals and physicians (model 4) to achieve improvements in quality and shared savings. To the extent that there are opportunities for nurses to be involved in care coordination, it would be through the Awardee which is the risk-bearing entity (generally a hospital in model 2, an SNF or home health agency in model 3, and always a hospital in model 4, which has 10 participants).

**Comprehensive Care for Joint Replacement (CJR) and Episode Payment Models (EPM):** CJR began April 1, 2016, and will run for approximately 5 years. CJR was originally implemented in 67 metropolitan statistical areas (MSA). Unlike the BCPI models, which are voluntary, CJR participation was originally mandatory for all hospitals within those areas. The mandatory aspect of CJR has been controversial. Former Health and Human Services (HHS) Secretary Tom Price introduced legislation delaying CJR prior to its implementation when he was a member of Congress.<sup>15</sup> On August 17, 2017 (while Price was still HHS Secretary), CMS proposed to reduce mandatory participation in CJR from 67 to 34 MSAs. Participation remains voluntary in the remaining 33 MSAs where CJR is underway.

CJR hospitals will receive separate episode target prices for lower extremity joint replacement (LEJR). All providers and suppliers are paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. At the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) is compared to the Medicare target episode price for the responsible hospital. Depending on the participant hospital’s quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

CJR is intended to provide incentives to create more provider investment in infrastructure and redesigned care processes for higher quality and more efficient service delivery, and higher value care across the inpatient and postacute care (PAC) spectrum spanning the episode of care. Like BPCI, there is no specific payment for care coordination but the hospital is given incentives to work with physicians, practitioners, PAC providers, and others involved in patient treatment and recovery for LEJR.<sup>16</sup>

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<sup>15</sup> Vote Smart. (2016). *Reps. Price & Scott introduce bill to protect access to quality care: Statement*. Retrieved from <https://votesmart.org/public-statement/1055069/reps-price-scott-introduce-bill-to-protect-access-to-quality-care#.WdE1Ba2ZOHo>

<sup>16</sup> Medicare Program: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower

Of particular note, CJR waives requirements for nurses and other licensed clinical personnel to work under the direct supervision of a physician or an APRN when providing postdischarge visits in the patient's home or place of residence any time during the episode. In this circumstance, the patient is not eligible for home health services but the physician, APRN, or hospital could bill for the service of a nurse providing a home visit under the "incident to" benefit, provided the general supervision requirement is met and the nurse is employed (either directly or under contract) by the person or entity that is billing for the service. It is also worth noting that the CJR waiver allows this home visit by a nurse to be paid outside of Medicare's payment for the surgical procedure.<sup>17</sup>

On December 20, 2016, CMS finalized new EPM models for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), Surgical Hip and Femur Fracture (SHFFT), and Cardiac Rehabilitation Incentive Payment Models. EPMs were designed to work similarly to CJR. Based on its experience with CJR, CMS made some regulatory changes for EPMs that it also adopted for CJR. The first performance period for the new EPMs (the AMI, CABG, and SHFFT Models) and the Cardiac Rehabilitation (CR) Incentive Payment Model was originally scheduled to begin on July 1, 2017 and last until December 31, 2021. The AMI and CABG models were to be implemented in 98 metropolitan areas while the SHFFT model was to be implemented in the same 67 MSAs where the CJR Model is currently underway. However, CMS proposed to cancel EPMs and the CR Model in its August 17, 2017 proposed rule. At this time, the changes to CJR and cancellation of EPMs and the CR Model remain in the proposed rule stage awaiting the publication of final regulations. Since the proposed cancellation of EPMs and CR and the changes to CJR, Tom Price resigned as Secretary of Health and Human Services for reasons unrelated to these models.

Like CJR, if implemented, the EPM regulations would allow for CABG and SHFFT postsurgical discharge visits by clinical staff in the home under general supervision in addition to Medicare's payment for the surgical service and postoperative care. If implemented, each model would have specific numerical limits for these waiver-enabled postdischarge visits. Again, special waivers of existing regulations in the EPM for CABG and SHFFT would allow opportunities for nurses to be involved in care coordination where they may not be under the normal rules.

In the CR model, CMS planned to waive statutory restrictions that only allow physicians to be paid for furnishing specific cardiac and intensive cardiac rehabilitation services. If implemented, this waiver would allow APRNs to prescribe cardiac rehabilitation, create the treatment plan, and supervise cardiac rehabilitation services. If implemented, the CR model is intended to facilitate cardiac rehabilitation participation by patients, especially for 12 or more sessions, by increasing the add-on payment per session from \$25 for the first 11 sessions up to \$175 for the twelfth and subsequent visits (payments are made to the hospital where the patient was treated under the AMI or CABG model). If implemented, the cardiac rehabilitation incentive payment model would provide APRNs with opportunities to be part of or take the lead in providing continuity-of-care coordination as a patient transitions from the hospital and postacute care program into an outpatient cardiac rehabilitation program.

## V. Statutory or Regulatory Changes to Facilitate Access to Nursing Services

**Make Payment to NPs and CNSs at the Same Rate as Physicians:** As stated earlier, the Medicare statute requires NPs and CNSs to be paid 85% of what Medicare would pay a physician for the same service or 85%

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Extremity Joint Replacement Services; Final Rule. 80 FR 73273 (24 November 2015), p. 73441.

<sup>17</sup> Medicare makes a single payment for a surgical procedure and all postoperative visits for a specified number of days following the surgery (0, 10, or 90, depending on the surgery). The surgeon cannot bill separately for postoperative visits related to the surgical service. The CJR waiver allows Medicare payment for the home visit in addition to payment for visits included in the global period.



of the MPFS payment amount. This same 85% limitation also applies to the services of PAs and medical nutrition therapy furnished by Registered Dietitians or nutrition professionals. Clinical Social Workers (CSWs) are paid at 75% of the amount that Medicare would pay qualified psychologists for the same service. Until January 1, 2011, CNMs were paid 65% of the MPFS payment amount. Beginning January 1, 2011, Medicare pays CNMs 100% of the MPFS amount.

*How did this statutory limitation originate?*

Direct payment by Medicare to NPs and CNSs appears to date back to the Omnibus Budget Reconciliation Act (OBRA) of 1990 effective January 1, 1991. At that time, direct payment was limited to NPs and CNSs in rural areas and equaled 75% of the PFS amount for services furnished in a hospital and 85% of the PFS amount for other services.<sup>18</sup> The NP and CNS benefit was significantly expanded by the Balanced Budget Act (BBA) of 1997. The BBA removed the limitation on setting and made payment equal to 85% of the PFS amount in all circumstances.<sup>19</sup> Neither the OBRA 1990 or the BBA 1997 Conference Report provide any guidance as to why the payment limitation for NPs and CNSs is at 85% of the PFS amount (although it is important to note that there is precedent for increasing the limitation because it went from 75% to 85% in the BBA for services furnished in the hospital).

*What are the arguments for and against this statutory limitation?*

In the absence of finding any legislative history explaining the basis for the limitation, one can only speculate as to its rationale. One possibility is that NPs and CNSs—as well as other practitioners paid at a percentage of the same service performed by a physician or as a percentage of the same service performed by a psychologist in the case of CWSs—are paid less than physicians because of their different education and training. However, there are other practitioners that receive Medicare payment under PFS with different training than physicians that are not subject to the same payment limitations as NPs, CNSs, and other nonphysician practitioners—specifically, dentists, optometrists, and podiatrists. A commonality among these latter three professions and MDs and DOs is that they all meet the definition of “physician” provided for in section 1861(r) of the Act. However, unlike MDs and DOs, dentists, optometrists and podiatrists have limited licenses. The breadth of education and training across the professions that meet the 1861(r) definition of physician is difficult to compare. Nevertheless, dentists, optometrists, podiatrists, and APRNs, unlike MDs and DOs, all have limited licenses yet dentists, optometrists, and podiatrists are not subject to the same payment limitation as APRNs. MDs and DOs have unlimited licenses; their training and qualifications allow them to provide more services than APRNs, dentists, optometrists, and podiatrists. It does not logically follow, however, that NPs and CNSs should then be paid less than physicians when doing the same services that are within their state scope of practice and training. A principal of the MPFS is that it pays the same amount for a service irrespective of who does it. Section 1848(c)(6) of the Act specifically prohibits paying differentially based on the specialty of the physician, yet other provisions of the statute produce the result of Medicare paying differentially for the same service depending upon whether it is done by an NP or CNS versus a physician, dentist, optometrist, or podiatrist or, for that matter, other APRNs. Provisions expanding the benefit category for NP and CNSs occurred in the BBA 1997, 5 years after adoption of the Medicare physician fee schedule eliminated Medicare specialty payment differentials and implicitly rejected the notion that length of education, years of practice, or physician specialty were reason for paying different amounts to physicians for doing the same service yet maintained a payment limitation for NPs, CNSs, and other practitioners.

The statute resulted in Medicare paying less to NPs and CNSs to do the same services than it does to CRNAs and CNMs. It does not appear logical to pay APRNs differently for the same service depending upon whether

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<sup>18</sup> Omnibus Budget Reconciliation Act of 1990: conference report to accompany H.R. 5835, (October 27, 1990), p. 757. Retrieved from: [https://archive.org/details/omnibusbudgetrec00unit\\_11](https://archive.org/details/omnibusbudgetrec00unit_11)

<sup>19</sup> Balanced Budget of 1997 Conference Report, (July 30, 1997), p 779. Retrieved from: <https://www.gpo.gov/fdsys/pkg/CRPT-105hrpt217/pdf/CRPT-105hrpt217.pdf>

the APRN is an NP, CNS, CRNA, or CNM. Under current policy, the benefit category for CRNAs, CNMs, NPs, and CNSs is only limited by state scope-of-practice laws, which means that each of these types of APRNs is likely be able to be paid for the same services—E/M services, for example—yet CRNAs and CNMs will be paid more than NPs and CNS for doing the same services.

The more likely reason that Congress applied the limitation on payment to NPs, CNSs, and other nonphysician practitioners is budgetary: payment to NPs, CNSs, and other nonphysician practitioners is less costly with the payment limits. Conversely, eliminating those payment limits will have a cost that Congress may not want to incur.

#### *Is there precedent for eliminating the payment limitation?*

There is precedent for eliminating payment limitations. In the Affordable Care Act, Congress eliminated the 75% payment limitation that applies to CNMs. However, Medicare beneficiaries are primarily 65 or older and the under-65 population eligible for Medicare must have a disability lasting more than 2 years, so it is likely that few Medicare beneficiaries are receiving the obstetrical services provided by CNMs. Therefore, the cost of eliminating the CNM limitation was likely minimal.

OBRA 1987, OBRA 1989, and OBRA 1990 established payment limits for new physicians equal to 80%, 85%, 90%, and 95% respectively in their first through fourth years of practice.<sup>20</sup> These limitations were eliminated by OBRA 1993. When Congress eliminated the new-physician payment limitation, the statute required the change to be made budget-neutral. Meeting this stipulation required a downward adjustment to all PFS rates, so all practitioners receiving payment under the PFS paid for the elimination of the new-physician adjustment with a reduction in the rates they received from Medicare.

#### *Will these precedents help the nursing community argue for removing the limitation?*

These precedents, while helpful for illustrating that Congress previously eliminated a payment limitation, are not helpful in overcoming any cost arguments that will be a barrier to enacting legislation to eliminate the payment limitation for NPs and CNSs. In one case, the costs were low to eliminate the limitation while in the other, Congress enacted the provision so it would be budget-neutral. Further, Congress will be sensitive to arguments from other nonphysician practitioners to eliminate the same or similar payment limitations, which will make them more reluctant to address this issue for cost reasons.

#### *What are the other options for arguing to remove the limitation?*

One potential option for addressing the cost issue is to make elimination of the payment limitations budget-neutral through an adjustment to PFS rates as occurred when the new-physician payment limitation was eliminated. However, such a proposal is likely to be strenuously objected to by the physician community and create interprofessional conflicts. Another option for trying to eliminate the NP and CNS cost limitation is to offer or use an offsetting savings proposal to fund the provision's cost. The potential options here could be limitless and, to be successful, would likely require leadership of the nursing community to be engaged in the political process at the time Congress is enacting legislation.

#### *Are there any other policy changes that would help facilitate payment to APRNs?*

Medicare policy with respect to APRNs is not always consistent. Section 1861(r) of the Act defines “physician” to include medical doctors (MD), doctors of osteopathy (DO), dentists, optometrists, podiatrists, and chiropractors (the last for the limited circumstance of manual manipulation of the spine to treat a subluxation as demonstrated by an X-ray). In some contexts, CMS views the term “physician” as being limited to MDs, DOs, dentists, optometrists, and podiatrists. In other contexts, CMS has used a more expansive definition of “physician.” The discussion below outlines four different circumstances that we

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<sup>20</sup>Omnibus Budget Reconciliation Act of 1990: conference report to accompany H.R. 5835, (October 27, 1990), p. 732, 733 and 738. Retrieved from: [https://archive.org/details/omnibusbudgetrec00unit\\_11](https://archive.org/details/omnibusbudgetrec00unit_11)

know of that illustrate different use of the term “physician” and how it applies to APRNs’ ability to supervise and be paid for services furnished to Medicare patients. There may be others.

1. **“Incident to” Services:** As explained above, Medicare requires that “incident to” services be furnished under the supervision of a physician or a nonphysician practitioner such as an APRN. However, CMS has not always allowed APRNs and other nonphysician practitioners to supervise “incident to” services. In its 2009 OPPS final rule, CMS indicated that it views the supervision requirement as emanating from the “incident to physicians’ services” language in the Medicare statute. The final rule states:

[I]t would not be in accordance with the law and regulations for a non-physician practitioner to be providing the physician supervision in a provider-based department, even if a nurse practitioner’s or a physician assistant’s professional service was being billed as a nurse practitioner or a physician assistant service and not a physician service.<sup>21</sup>

CMS is stating that because the statute is describing the “incident to” benefit as “incident to a physician’s service,” supervision can only be provided by a physician as defined in section 1861(r) of the Act (generally meaning an MD or DO but may include dentists, optometrists, and podiatrists). One year later, CMS changed its policy and allowed APRNs and other nonphysician practitioners to supervise “incident to” services on the basis that these practitioners “are recognized in statute and regulation as providing services that are analogous to physicians’ services.”<sup>22</sup>

While CMS viewed the term “physician” as limiting who can supervise “incident to” services in 2008, CMS found a basis to expand its policy to include APRNs and other nonphysician practitioners even though the statute was unchanged.

2. **Supervision of Diagnostic Tests:** CMS policy continues to preclude APRNs from supervising diagnostic services. Section 1861(s)(3) describes the diagnostic services benefit category as including “diagnostic X-ray tests (including tests under the supervision of a physician...” Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15, section 80 states

Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act).

The same rationale for how CMS was able to allow APRNs to supervise “incident to” services could equally apply to the supervision of diagnostic services—that is, CMS could allow supervision of diagnostic services beyond the 1861(r) definition of a physician to include APRNs because APRNs “are recognized in statute and regulation as providing services that are analogous to physicians’ services.”

3. **Supervision of Cardiac and Intensive Cardiac Rehabilitation Services:** In its final rule implementing statutory provisions that create a new benefit category for cardiac and intensive cardiac rehabilitation, CMS indicates that APRNs and other nonphysician practitioners do not meet the requirement to supervise these services because the statutory language of the MIPPA [Medicare Improvements for Patients and Providers Act of 2008] defines both cardiac rehabilitation and intensive cardiac rehabilitation as “physician-supervised” programs. A physician is defined in section 1861(r)(1) of the Act. The MIPPA also specifically requires that “a physician is immediately available and accessible for

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<sup>21</sup> Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates. 73 FR 68922 (18 November 2008), p. 68704.

<sup>22</sup> Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates. 74 FR 60315 (20 November 2009), p. 60578.

medical consultation and medical emergencies at all times items and services are being furnished under the program.

The text of the statute uses the word “physician” and does not include NPs.<sup>23</sup> Again, CMS argues that the statutory use of the term “physician” limits supervision of cardiac and intensive cardiac rehabilitation services to physicians as defined in section 1861(r)—generally MDs and DOs. However, the same rationale for how CMS was able to allow APRNs to supervise “incident to” services could equally apply to supervision of cardiac and intensive cardiac rehabilitation services—that is, CMS could allow supervision of diagnostic services beyond the 1861(r) definition of a physician to include APRNs because APRNs “are recognized in statute and regulation as providing services that are analogous to physicians’ services.”

4. **ACO Program:** In the 2011 ACO final rule, CMS indicated that it could not include the primary care services furnished by NPs and PAs to assign a beneficiary to an ACO because the statute requires CMS to use only the part of the definition of ACO professional encompassed by section 1899(h)(1)(A) and not 1899(h)(1)(B). Section 1899(h)(1)(A) of the Act is limited to the section 1861(r) definition of a physician (generally meaning MDs and DOs) while section 1899(h)(1)(B) includes nonphysician practitioners such as NPs.<sup>24</sup> However, in the 2015 ACO final rule, CMS changed policy, allowing primary care services furnished by NPs and PAs to be used in the attribution process because these practitioners are included in the definition of “primary care practitioner” in another provision of the statute that is unrelated to the ACO program.<sup>25</sup>

**Change the Statute to Allow Direct Payment to Registered Nurses (RN):** Under current law, there is no explicit benefit category that would allow Medicare to make direct payment to RNs like there is for the specific APRNs of NP, CNS, CNM, and CRNA. Payment can only occur through another explicitly described benefit category (such as inpatient hospital services, skilled nursing facility, “incident to,” etc.). For Medicare to make direct payment to RNs for care coordination activities instead of through another benefit category to the RN’s employer, Congress would have to change the statute to explicitly add a benefit category for RNs and describe the services they provide that could be paid by Medicare.

*How likely is that the Medicare statute could be changed to allow direct to payment to RNs?*

Achieving a statutory change to allow direct payment to RNs will be challenging. There are many healthcare practitioners seeking direct payment from Medicare, including but not limited to pharmacists, radiology assistants, radiology practice assistants, licensed professional counselors, and marriage and family counselors, among others.

This paper is not evaluating the relative merits of establishing direct payment for RNs compared to any of these other practitioners. It is only noting that the interest among so many different practitioners will make Congress reluctant to change the statute in the absence of a significant and persuasive argument for why the Medicare statute should be changed to allow direct payment for one type of practitioner while not allowing it for others seeking the same treatment. This obstacle would be in addition to others, such as objections from hospitals and physicians and potentially others that currently employ RNs, as well as costs and other practical difficulties.

Section 435 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 provides a salient example of the challenge that would be faced to change the statute to create a separate

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<sup>23</sup> Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010. 74 FR 61737 (25 November 2009), p. 61875.

<sup>24</sup> Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations; Final Rule. 76 FR 67801 (2 November 2011), p. 67856.

<sup>25</sup> Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations; Final Rule. 80 FR 32691 (9 June 2015), p. 32748.

benefit category for RNs. Section 435 of BIPA required the Medicare Payment Advisory Commission (MedPAC) to study the appropriateness of providing Medicare coverage for the services of:

1. Surgical technologists (MedPAC’s discussion also includes registered nurse first assistants-at-surgery in this discussion];
2. Marriage counselors;
3. Marriage and family therapists; and
4. Licensed professional counselors of mental health.

BIPA required that MedPAC report on the short-term and long-term benefits and costs associated with providing these additional Medicare benefits. In response to a separate Congressional request, MedPAC evaluated Medicare coverage for clinical pharmacists providing drug therapy management.

MedPAC completed its Report to Congress in June 2002. While MedPAC’s report was completed more than 15 years ago, it did not recommend separate payment for any of these types of practitioners.<sup>26</sup> Nor have any of these professions since that time been successful in obtaining direct Medicare payment for their services, which suggests the difficulties RNs face in successfully obtaining a statutory change to achieve their goal.

MedPAC’s report was completed in 2002, before Medicare had the separate Part D benefit for prescription drugs. MedPAC recommended that the “Secretary should assess models for collaborative drug therapy management services in outpatient settings.” The report indicated that “Congress could consider drug management services together with comprehensive care coordination for Medicare beneficiaries” and added further the “need to clearly defines the roles and responsibilities of pharmacists, physician and other providers on the patient care team.”<sup>27</sup> These types of pharmacist services may be analogous to the kind of care coordination services for which RNs are seeking direct payment. Despite the creation of the Medicare Part D prescription drug benefit more than 10 years ago, there is still no statutory benefit category that allows direct payment to clinical pharmacists for the types of services described by MedPAC. The lack of direct Medicare payment to pharmacists despite the creation of the Medicare Part D benefit further suggests challenges that RNs face in obtaining direct payment from Medicare.

Of significance to RNs in MedPAC’s analysis is its focus on access to services.<sup>28</sup> Evaluating access to services may be a key variable for Congress to determine whether to amend the statute to provide direct payment to RNs for the services they provide. A statutory change to allow direct Medicare payment for RNs would be evaluated by Congress relative to how payment is occurring now—indirectly to nurses through the “incident to” and other benefit categories that include the services of nurses. Rather than seeing the statutory change as covering a service not currently covered and paid by Medicare, the change would be evaluated as paying directly for RN services instead of through their employer or to whom RNs are under contract. If the perception in Congress is that paying RNs directly would only change how Medicare pays for nursing services rather than improving access or serving another public policy goal, Congress would be unlikely to change the statute, particularly if doing so would have a significant cost. However, if RNs could demonstrate that direct payment for their services would improve access to services where it does not currently exist, RNs may be in a better position to obtain direct Medicare payment.

*Are there any models that provide examples for RNs to follow to seek direct payment from Medicare?*

Over time, Medicare has created a number of new benefit categories. Other than the benefit categories for NPs and CNSs, the most relevant example for a new benefit category for RN services is probably medical nutrition therapy (MNT).

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<sup>26</sup> Medicare Payment Advisory Commission. (2002). *Report to Congress: Medicare coverage of nonphysician practitioners*, pp. vii–viii.

<sup>27</sup> Medicare Payment Advisory Commission. (2002). *Report to Congress: Medicare coverage of nonphysician practitioners*, p. 25.

<sup>28</sup> Medicare Payment Advisory Commission. (2002). *Report to Congress: Medicare coverage of nonphysician practitioners*, pp. 14–18.

Effective January 1, 2002, BIPA added a new benefit category for “medical nutrition therapy services” which are defined as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional...pursuant to a referral by a physician.” The registered dietitian (RD) or nutrition professional must have a baccalaureate degree or higher and have completed 900 hours of supervised training under the direction of a dietitian or nutrition professional and be state licensed or meet other qualifications established by the Secretary if the state in which the nutrition professional or dietitian is practicing does not license nutrition professionals or dietitians. The benefit is limited to beneficiaries with diabetes that have not received diabetes self-management training and patients with renal disease not receiving dialysis.

The relevance of MNT to Congress creating a new benefit category to make direct Medicare payment to RNs is that Medicare is providing payment to a type of healthcare practitioner that is educated at the baccalaureate level, which is what ANA is seeking for RNs. However, MNT may not be the best analog to paying for RN services because Medicare is paying a new professional for services not previously paid for by Medicare. It is possible, although unlikely, that prior to creation of the MNT benefit, Medicare paid for MNT services to a physician through the “incident to” benefit. In this case, the physician would have needed to employ staff providing MNT services and could have potentially billed for those services as part of an E/M service. It seems unlikely that physicians in most cases would have employed an RD or nutrition professional to provide these services. More likely is that these services were not being provided prior to the creation of the MNT benefit or the services were provided but not covered and Medicare beneficiaries would have had to pay for MNT services themselves. RNs are seeking payment for nursing services for which Medicare is already paying through the “incident to” and other Medicare benefit categories.

*Are there any ways other than a change in statute to obtain direct payment for RN services?*

Section 3021 of the Affordable Care Act established CMMI and a new demonstration authority under newly created section 1115A of the Act. The new demonstration authority allows the Secretary of Health and Human Services to waive provisions of statute and regulations to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care. The statute directs the Secretary to give preference to models that improve the coordination, quality, and efficiency of healthcare services furnished to Medicare and Medicaid beneficiaries. The Secretary is prohibited from requiring initial budget neutrality as a condition for approving a model to be tested. Section 1115A(c) provides that the Secretary may expand the duration and the scope of a model through rulemaking, including implementation on a nationwide basis provided the model reduces spending without reducing the quality of care or improves the quality of patient care without increasing spending, and the CMS Chief Actuary certifies that such expansion would reduce or not result in any increase in net program Medicare program spending and does not deny or limit Medicare benefits.

There should be consideration as to whether it is possible to test a different model of payment to RNs through the CMMI waiver authority. CMS is creating the Medicare Diabetes Prevention Program (MDPP) under this authority. Working together with the Centers for Disease Control and Prevention (CDC), in 2012 CMS made a Health Care Innovation Award and used its waiver authority to pay CDC-accredited diabetes prevention programs that train eligible patients in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. CMS adopted a policy to expand the MDPP nationwide effective January 1, 201, under the authority of section 1115A(c) of the Act, indicating that the CMS Chief Actuary certified that the MDPP improved quality of care without increasing spending and does not deny or limit Medicare benefits.<sup>29</sup>

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<sup>29</sup> Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017. 81 FR 80170 (15 November 2016), pp. 80460–80461.

Using the CMMI waiver authorities will also present challenges. First, the CMS website says that CMMI “does not fund unsolicited proposals but does use such ideas to inform model development.” However, the website does further state that CMMI “is working in consultation with clinicians to increase the number and variety of models available to ensure that a wide range of clinicians, including those in small practices and rural areas, have the option to participate.” Second, CMMI went through two rounds of Health Care Innovation Awards (in 2012 and 2014). There is no indication on the CMMI website that there are any plans for another round of Health Care Innovation Awards.<sup>30</sup>

## VI. Conclusions and Recommendations

Recent changes in Medicare policy have provided opportunities for RNs to be more involved in care coordination activities more independently than they have been in the past, at least in those instances where Medicare is allowing for general supervision and not requiring direct supervision of a service, as well as those program areas where support of care coordination activities may lead to shared savings. However, payment to RNs for care coordination activities will remain through a physician or another practitioner or provider with the ability to direct-bill Medicare rather than directly to an RN.

There are two potential avenues to change this result: 1) seeking a change in statute or 2) convincing CMS to use its section 1115A waiver authority to study direct payment to RNs.

However, for RNs to be successful under either avenue, RNs will need to present a strong argument for why payment should be made to them directly rather than through others as is done now, as well as specify the scope of services for which they would be paid directly.

This paper provides examples of how Congress or CMMI created a new Medicare benefit that may provide guidance for how ANA could proceed further. For instance, MNT and the MDPP are defined and circumscribed Medicare services that may provide a model for how RNs could describe a service they do that could be identified and separately paid for by Medicare.

Another commonality among some of the services described above is that they have literature that supports their efficacy. CDC created the MDPP benefit and convinced CMMI to support it through Medicare because of research supporting the premise that a structured program of lifestyle changes including diet and exercise could avoid or delay the onset of diabetes in people with prediabetes.<sup>31</sup> Literature supporting CoCM made CMS more inclined to create a code for this service so it could be distinctly recognized.<sup>32</sup> Legislative history supporting MNT was not found, but, presumably, Congress was convinced to support this new benefit because the program’s proponents could support the beneficial health effects for eligible patients (patients with diabetes and renal disease not receiving dialysis).

In summary, the above examples may provide guidance to the nursing community for how to define a circumscribed benefit that could be supported by existing or new literature that demonstrates how payment for that service could provide a public policy benefit (improved health outcomes, lower health care costs, increased access to services that are not currently available, etc.) to put RNs in a better position to argue for direct payment for the services they provide.

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<sup>30</sup> Centers for Medicare & Medicaid Services. (2017). *About the CMS Innovation Center*. Retrieved from <https://innovation.cms.gov/About/index.html>

<sup>31</sup> National Institute of Diabetes and Digestive and Kidney Disease. (n.d.). *Diabetes Prevention Program (DPP)*. Retrieved from <https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Pages/default.aspx>

<sup>32</sup> Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule. 81 FR 8017 (15 November 2016), p. 80230.