

**Implementing Health Care Reform:
Issues for Nursing**

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I. INTRODUCTION

In March of this year, President Obama signed into law two milestone pieces of health reform legislation, the Affordable Care Act (P.L. 111-148) and the Health Care Education and Reconciliation Act of 2010 (P.L. 111-152). The American Academy of Nursing, along with many other nursing organizations, has strongly supported the Administration's efforts to reform health care, recognizing their potential to expand access to cost-effective, high-quality care and to help shift the U.S. health system toward a greater emphasis on primary and preventive care.

These goals have been priorities for our profession for decades. Nursing was the first of the health professions to support the creation of the Medicare program in 1958, despite vocal opposition at that time from medicine and the hospital industry¹. Nursing organizations united around a common health reform platform, Nursing's Agenda for Health Care Reform, in the early 1990s², and many nursing groups actively supported the Clinton Administration's reform proposals in 1993-94³. Despite the defeat of federal health reform in 1994, nursing has continued to press for fundamental changes in the health system. In 2009 over 40 nursing organizations (including the Academy) endorsed "Commitment to Quality Health Reform: A Consensus Statement from the Nursing Community," outlining common recommendations to be included in health reform legislation⁴.

In 2006, the American Academy of Nursing launched its "Raise the Voice" campaign⁵, emphasizing the roles that nursing can play in transforming health care delivery. This campaign has highlighted the examples set by Edge Runners—nurses who have initiated innovative, nurse-led models of care that have expanded access, extended and improved care to communities. These pioneering nurses have carried on their work, often confronting substantial barriers such as inadequate payment for advanced practice nursing services, cumbersome health plan policies, and government regulations and policies that often require unnecessary and duplicative oversight by other health professionals.

The new health reform laws provide a complex series of changes in health care delivery, payment, coverage and education—some of them immediate and others to be introduced or phased in over five years. Several provisions recognize and broaden the roles of nurses, particularly advanced practice registered nurses (APRNs)⁶, in expanding access to primary care and other health services. Some of these expand the work of Academy Edge Runners. For example, Section 3026 of the ACA will help to replicate the

¹ "Taking a Stand." (1959). *American Journal of Nursing* 59 (9): 1245

² American Nurses Association (1992). *Nursing's Agenda for Health Care Reform*. Washington, DC: ANA.

³ Betts, V.T. (1994). Nursing's agenda for health care reform: Policy, politics and power through professional leadership. *Nursing Administration Quarterly*, 20 (3): 1-8

⁴ See <http://www.thenursingcommunity.org/#/health-reform/4542347781>

⁵ See <http://www.aannet.org/raisethevoice>

⁶ *Advanced practice registered nurse (APRN)* is an umbrella term that includes nurse practitioners, certified nurse-midwives, clinical nurse specialists and certified registered nurse anesthetists.

transitional care model developed by Mary Naylor, PhD, RN, FAAN. Section 2951, authorizing Maternal, Infant, and Early Childhood Home Visiting Programs, creates opportunities to expand the Nurse-Family Partnership.

Several other provisions authorize important new funding for nurse-led care models, such as Nurse-Managed Health Clinics. And several provisions authorize critical new resources for expanding the health care workforce, including programs to increase the supply of APRNs and other registered nurses to meet growing health care needs, especially for primary and preventive services—a particularly critical need presented by the anticipated expansion of health care coverage to 32 million uninsured Americans.

Nursing has a central role to play in realizing the promise of health reform—a transformed health system that provides wide access to essential health services while improving quality and controlling costs. Simply put, **these national goals cannot be achieved without maximizing the contributions of nurses.**

This paper outlines some of the major provisions that have a real or potential impact on nursing's role in health reform. The paper also identifies related areas in which additional legislation may be necessary. In general, our approach is to identify steps that the Administration can take in order to maximize nurses' potential for advancing and achieving the mutual goals of achieving access to cost-effective, high quality care for the greatest possible numbers of Americans.

The recommendations in this paper were developed in dialogue with key national nursing organizations although this is not a consensus document. There is general agreement among these organizations on many of the recommendations. On some issues, there is agreement on goals and ongoing discussion about how best to achieve them: for example, work is proceeding on identifying federal strategies for addressing (directly or indirectly) state barriers to full utilization of APRNs.

The recommendations included in this paper have been developed to provide a basis for further discussion with Federal agencies and Administration officials regarding effective implementation of health reform legislation. Where appropriate, we have also included background information to help provide the context and rationale for our recommendations.

II. ADVANCING ACCESS TO CARE THROUGH FULL UTILIZATION OF APRNs

The evidence that APRNs provide high quality care is overwhelming⁷. The Administration has repeatedly recognized the crucial role that nurses must play in

⁷ Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, & Sibbald B (2004). Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews* 2004, Issue 4. Art. No.: CD001271. DOI: 10.1002/14651858.CD001271.pub2; Dulisse, B. & Cromwell, J. (2010). No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. *Health Affairs*, 29(8):1469-1475; Lenz ER, Horrocks S, Anderson E, and Salisbury C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent

achieving the goals of health reform, including fostering access to affordable, quality, equitable, appropriate health care. It can continue to demonstrate this recognition through careful implementation of health reform provisions in a manner that solidifies or clarifies nursing's roles.

At the same time, however, ongoing barriers to nursing practice in private health plan policies, many state laws and even in many current federal laws and rules threaten to impede the full utilization of nurses. These barriers to nursing practice must also be addressed if the goals of health reform are to be met.

A. Discrimination by private insurers and health plans

Background: Many private insurers and health plans have impeded consumer access to APRN services—either by failing to cover those services at all, requiring physician oversight, refusing to recognize APRNs as primary or specialty care providers, or paying for them at lower rates. Many health plans refuse to include APRNs in their provider directories. Thus patients are often unable to select an APRN as their provider—effectively limiting consumer choice and provider availability, especially in underserved areas. Many APRN practices must either forego private health plan reimbursement or enter into a contractual relationship with a physician to bill services under the physician's name, although even this is not possible with some health plans.⁸ This situation affects not only privately insured individuals, but also Medicare beneficiaries enrolled in Medicare Advantage plans and Medicaid recipients who receive their services through managed care plans.

Among the private health insurance reforms introduced by Section 1201 of the ACA is a new Section 2706 of the Public Health Service Act, "Non-discrimination in health care." This provision, which goes into effect in 2014, states that health plans (including group and individual plans) "shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." This provision can play a significant role in promoting greater access by consumers to APRN services. However, strong enforcement will be important in order to ensure that this goal is realized.

Recommendation:

- **Regulatory: To be effective, this prohibition on discrimination needs to be backed by clear enforcement mechanisms and penalties for non-compliance. Ongoing dialogue between nursing organizations and the Administration regarding effective enforcement of non-discrimination will**

care to doctors. *BMJ*, 324 (7341): 819–23; Dierick-van Daele AT, Metsemakers JF, Derckx EW, Spreeuwenberg C, & Vrijhoef HJ. (2009). Nurse practitioners substituting for general practitioners: randomized controlled trial. *Journal of Advanced Nursing*, 65(2):391–401;

⁸ Hansen-Turton, T., Ritter, A., & Torgan, R. (2008). Insurers' contracting policies on nurse practitioners as primary care providers: two years later. *Policy, Politics & Nursing Practice*, 9(4), 241–248; Hansen-Turton, T., Ritter, A., Begun, H., Berkowitz, S., Rothman, N., & Valdez, B. (2006). Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change. *Policy, Politics & Nursing Practice*, 7(3), 216–226.

be important.

B. State practice acts

Background: Each state has its own laws regarding nurse licensure, regulation and scope of practice. For APRNs, these laws vary considerably. Some states have sought to maximize the utilization of APRNs by authorizing them to practice without a statutory relationship with a physician.⁹ In other states, one or another form of statutory physician involvement with APRNs is required, ranging in degree of severity and restrictiveness.¹⁰ There is no evidence that patient safety or quality have been compromised as a result of APRNs being authorized to practice without physician involvement. Conscientious practice will always dictate when any provider—regardless of her or his profession—seeks consultation from or collaboration with others. Indeed, APRNs have a strong record of practicing successfully in interprofessional teams. But rigid state collaboration requirements often require duplication of services by mandating physician involvement in nurse practitioner care. Especially where NP practices must hire or contract with physicians to provide statutory supervision or collaboration, these requirements also unnecessarily add to the cost of services. The requirements can also interfere with patients getting the services they need in a timely, efficient manner and make it more difficult for APRNs to establish their own practices, expand their practices into rural, inner-city or other underserved communities, or set up practices in non-traditional settings.

Recommendation:

- ***Legislative & Regulatory: In collaboration with nursing organizations, commit to strategies to override or remove restrictions on nursing practice in state scope of practice laws and regulations.***

C. Federal policy

1. Restrictions on APRN practice

Background: Some federal laws and rules also impede access to quality health care services by preventing full and efficient utilization of APRNs. For example, in order for services to be covered by Medicare, an NP or CNS must be “working in collaboration with a physician.”¹¹ This federal requirement applies to services provided in all states, even those states that do not require physician collaboration.^{12,13} (Physician supervision

⁹ The Pearson Report: 2010 Summary Table <http://www.pearsonreport.com/summary>

¹⁰ See Pohl, J.M., Hanson, C., Newland, J.A. & Cronenwett, L. (2010). Unleashing nurse practitioners’ potential to deliver primary care and lead teams. *Health Affairs*, 29 (5): 900-905; Christian S, Dower CM, and O’Neil E. (2007). Overview of nurse practitioners’ scopes of practice in the United States. San Francisco: University of California, Center for the Health Professions.

¹¹ Social Security Act, Section 1861(s)(2)(K)(ii).

¹² Federal rules specify that “In the absence of State law governing collaboration, collaboration is a process in which a nurse practitioner has a relationship with one or more physicians to deliver

of CRNA services is also required, but federal law gives states the ability to opt out of this requirement¹⁴). Other federal laws and rules restrict APRNs in other ways—for example, from certifying patients for home health or hospice services, or from performing admitting physicals on SNF patients. Removing unnecessary restrictions on practice would be an important step toward expanding consumer access to primary care and other important health services by encouraging fuller utilization of APRNs. Federal legislative and regulatory action will be needed to lift these barriers.

Further, health reform implementation language must not unnecessarily tie APRNs to physician practices—e.g., through mandating physician oversight or by requiring APRNs to function as members of teams led by other health professionals. (The Academy recognizes the important role of interprofessional health care teams but their leadership should be determined by the team and practice.)

2. Medicare payment

Medicare Part B services provided by nurse practitioners and clinical nurse specialists are paid at 85% of the amount physicians receive under the Medicare Fee Schedule. There is no rational basis for this differential, especially in a payment system designed to be based primarily on the value of services provided. Reduced payment can be a disincentive for health care organizations to use the best provider mix to meet the health needs of patients, such as with care coordination. The impact of this reduced payment is amplified by the fact that many private insurers base their payment policies on Medicare's. Notably, Section 3114 of the ACA raised Medicare payment for certified nurse-midwife services from 65% to 100% of the Medicare Fee Schedule effective January 1, 2011.

Recommendation:

- **The AAN believes that there is a need to establish payment rates that have a clear, rational basis and that—in order to increase access to services—are sufficient to support APRN-led practices and to remove disincentives to health care organizations for utilizing APRNs. Moreover, as efforts to test team-based approaches to care and provider payment continue, they will present opportunities to ensure integrated models of provider payment that rationally reflect APRNs' contributions to patient care. We look forward to ongoing discussions with the Administration and national nursing organizations concerned with this issue.**

health care services. Such collaboration is to be evidenced by nurse practitioners documenting the nurse practitioners' scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. Nurse practitioners must document this collaborative process with physicians.” 42 CFR 410.75(c)(3)(ii). A similar provision for CNS services is at 410.75(c)(3)(iii).

¹³ Notably, however, federal Medicaid law requires coverage of the services of a CNM, a certified pediatric NP or a certified family NP “whether or not [the CNM or NP] is under the supervision of, or associated with, a physician or other health care provider. Social Security Act Section 1905(a)(17) and (21).

¹⁴ 42 CFR §§482.52, 485.639 and 416.42

III. NURSING AND HEALTH CARE WORKFORCE

A. National Health Care Workforce Commission

Section 5101 of the ACA creates a National Health Care Workforce Commission to guide national health workforce policy. The Commission is given a broad scope in examining, reviewing, assessing and making recommendations regarding health care workforce capacity and planning. The National Center for Health Workforce Analysis in HRSA will provide much of the support for the Commission's work. Funding for the Commission is not mandatory.

While there is no designated seat for nursing (or any other profession) on the Commission, it is imperative that the Commission include at least one nurse. In fact, given the size and importance of the nursing profession, as well as the need for nurse workforce planning to be a major focus of the Commission's work, a strong case can be made for more than one nurse being named to the Commission—both in initial and subsequent appointments.

Recommendation:

- ***Appointment:* The Commission should always include at least one member who is a professional nurse.**

B. Title VIII Nursing Workforce Programs

Background: The ACA reauthorizes and updates several programs related to the nursing workforce under Title VIII of the Public Health Service Act. These programs are critical to preparing adequate numbers of registered nurses, including APRNs and other nurses with advanced education.

Recommendation:

- ***Budget:* Nursing organizations will continue to work closely with the Administration and Congressional leadership to ensure funding levels for Title VIII programs that can meet the nation's growing needs for nursing and health care services.**

B. Graduate Nurse Education demonstration

Background: Section 5509 of the ACA establishes a Medicare Graduate Nurse Education (GNE) demonstration program that will work with a combination of nursing schools, hospitals, and community-based clinical settings to provide funding for the clinical education of APRN students. The hospitals will act as pass through partners as well as clinical locations for the program. At least 50 percent of the funding will be directed toward the community-based clinical settings. The funds will be directed to nursing schools that are increasing capacity for APRN education to incentivize the schools to increase the numbers of APRN graduates. The program will cover the "reasonable costs" of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing APRNs with qualified training. Unfortunately, such "reasonable cost" reimbursement is based on the current Medicare

Graduate Medical Education reimbursement formula for hospital-based diploma programs. This formula is based on the number of Medicare hospital days and then divides in half the amount that could be charged by the hospital. Since a goal of the GNE demonstration program goal is to increase the numbers of community-based APRNs, this “reasonable cost” definition is inappropriate.

The GNE demonstration program is funded for only five hospitals at \$200 million for four years beginning in 2012 and the unused funds from one year will be allowed to be carried over to subsequent years during the duration of the demonstration.

Recommendations:

- ***Legislative & Regulatory:* Identify opportunities to expand this program to additional sites.**
- ***Regulatory:* Define “hospital” broadly, to include multi-hospital systems, in order to expand the number of eligible sites for this program.**
- ***Legislative:* Remove the current “reasonable cost” definition in Section 5509.**

C. Family Nurse Practitioner training programs

Background: Section 10501(e) of the ACA adds Section 5316 to the Public Health Service Act, providing for demonstration grants for FNP postgraduate training programs, offering one-year programs for NPs in FQHCs and NMHCs. Each site must have at least three NPs in its program. The program is authorized through 2015, with funds to be appropriated “as necessary each year.”

Recommendation:

- ***Budget:* Support continued adequate funding for this program.**

D. National Health Service Corps

Background: The National Health Service Corps (NHSC) provides health professionals to serve in designated health professions service areas (HPSAs), largely through service obligations for scholarship and loan repayment programs. Among the professionals eligible to participate in these programs are primary care NPs and CNMs.

In her remarks to the National Primary Care Nurse Practitioner Symposium in July, HRSA Administrator Mary Wakefield, PhD, RN, FAAN reported 1,700 APRN vacancies at the 1,400 NHSC locations across the country.

The NHSC previously received a much-needed infusion of funding from the Recovery Act. Section 5207 of the ACA reauthorizes the NHSC through 2015, authorizing approximately \$4 billion. Section 10503 of the ACA establishes a Community Health Centers Fund to expand support for Community Health Centers and the NHSC. It appropriates \$1.5 billion from this fund through 2015 to support NHSC.

Recommendation:

- **Working with nursing organizations and others, develop and implement aggressive education and outreach efforts to attract more nurses to fill these slots, including efforts to use the scholarship and loan repayments available**

- to incentivize more nurses to begin, complete, and more rapidly complete APRN education.**
- ***Budget:* Provide continued support of APRN students through NHSC's expanded programs.**

E. Public Health Sciences Track

Background: Section 5315 of the ACA establishes a U.S. Public Health Sciences Track to support health professions education that emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It will be organized to graduate at least 900 students, including 250 nursing students (the largest single category of students listed), 100 “physician assistant or nurse practitioner students,” and 100 behavioral and mental health professional students (among whom, presumably, could be psychiatric/mental health APRN students). Students receive tuition and a stipend for up to four years, after which they provide two years of service for every year of support (which may be reduced for service in a HPSA). The program will also include an integrated longitudinal plan for health professions continuing education and faculty development programs and curricula in decentralized settings. Funding of \$50,000,000 per year is authorized for 2010 through 2015.

Recommendation:

- ***Budget:* Support adequate funding for this important new program.**

F. Pediatric Healthcare Workforce loan repayment

Background: Section 5203 of ACA creates a new program under Section 775 of the Public Health Service Act to increase the supply of pediatric specialists in underserved areas. It will provide loan repayment in exchange for at least two years of service in a designated shortage area. Among the specialists eligible for this program are child and adolescent behavioral specialists from a number of disciplines, including psychiatric nursing. This part of the program is authorized at \$20 million per year through 2013.

Recommendations:

- ***Regulatory:* Ensure that psychiatric/mental health APRNs with training and experience in child and adolescent mental health will receive funding under this program.**

IV. DEVELOPING AND IMPLEMENTING INNOVATIVE MODELS OF CARE

A. Center for Medicare and Medicaid Innovation

Background: Section 3021 of ACA, modified by Section 10306, establishes a Center for Medicare and Medicaid Innovation (CMI) within CMS. CMI's purpose is “to test innovative payment and service delivery models to reduce program expenditures [in Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals” enrolled in these programs. In selecting such models, preference will be given to models that also improve the coordination, quality, and efficiency of health care

services furnished to individuals covered by Medicare, Medicaid or both and that are expected to reduce program costs while preserving or enhancing quality of care.

In carrying out its functions, the CMI is to “consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management.” The CMI will also use open door forums and other mechanisms to seek input from interested parties.

While participation in open door forums and other mechanisms for public input are important, nursing expertise in designing and evaluating innovative models of care is critical to ensure the success of projects selected and funded through the CMI.

Recommendation:

- ***Regulatory: Ensure that nurses, including APRNs, are among the “experts with expertise in medicine and health care management” with whom CMI will consult.***

The CMI will test payment and service delivery models to determine their effect on program expenditures and quality of care. To be selected, a model should show evidence that it addresses a defined population for which there are deficits in care that lead to poor clinical outcomes or potentially avoidable expenditures.

Recommendation:

- ***Regulatory: Ensure that nurse-led practices, including those by APRNs, are eligible and included in these models.***

1. Specific models identified in Section 3021 of the ACA

Several types of models are identified as eligible to be selected by CMI. Several of those that provide opportunities to test and demonstrate the effectiveness of nurse-led models of care are identified below. A common concern for nursing in all of the following models is to ensure that APRN-led practices will be included and funded in programs developed by CMI.

a. Innovative payment and service delivery models

- *Promote broad payment and practice reform in primary care, including patient-centered medical homes for high-need individuals and those that address women’s health care needs, and models that move primary care from fee-for-service reimbursement toward comprehensive or salary-based payment.*
- *Utilize geriatric assessment and comprehensive care plans to coordinate care (including care provided through interdisciplinary teams) for individuals with chronic conditions and either (1) an inability to perform two or more ADLs or (2) cognitive impairment.*
- *Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.*

- *Assist individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools that improve patient and caregiver understanding of treatment options.*
 - *Establish comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.*
 - *Directly contract with groups of providers and suppliers to promote innovative care delivery models, such as risk-based and salary-based payment.*
- Support care coordination for chronically ill individuals at high risk of hospitalization, using a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.*

Recommendation:

- **Regulatory: Ensure that nurse-led models, including APRN-led practices, are both eligible and encouraged to apply and that nurse-led models are among those selected and funded for these demonstrations to improve and enhance quality of care and provide data for comparative analyses.**

b. Electronic monitoring

- *Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.*

Recommendation:

- **Regulatory: Models that facilitate inpatient care through electronic monitoring using APRNs should be among those eligible, selected and funded.**

c. State-based models

- *Allow States to test and evaluate fully integrating care for dual eligible individuals, including the management and oversight of all Medicare and Medicaid funds for these individuals.*
- *Allow States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.*

Recommendation:

- **Regulatory: Ensure that such state models allow for full utilization of APRNs. Any private plans contracting with a state as part of such a model must**

ensure that, if they utilize provider networks, APRNs are included as network providers.

B. Medical homes and health homes

1. Ensuring broad participation by primary care providers

Background: The ACA includes two provisions aimed at expanding the use of medical home models to improve coordination and continuity of care, particularly for individuals with chronic conditions. Section 3502 establishes a program within Medicare for community health teams to support the patient-centered medical home, while Section 2703 establishes health homes for Medicaid recipients.

In order to advance broad utilization of medical home models, it is important that all primary care practices are eligible to participate. APRN-managed practices provide primary care services to a broad range of patients, including many patients with chronic conditions, often in underserved communities. APRNs and other registered nurses, working alone or with other professionals, are capable of providing many of the needed services.

Recommendations:

- **Regulatory:** Any federal guidelines or criteria for recognition as a medical home, or for eligibility for payment of care coordination or other services provided through medical homes, should include all types of primary care providers, including APRNs, as eligible practices.
- **Regulatory:** Any federal criteria for accepting recognition, designation or accreditation as a medical home by any private accrediting body should specify that the criteria for eligibility must include medical homes led by all types of primary care health providers, including APRNs.

2. Community health teams to support patient-centered medical homes

Background: ACA Section 3502, revised by Section 10321, requires the Secretary to establish a program through which states will initiate or contract with community health teams to support primary care services provided by patient-centered medical homes. Subsection 3502(c)(2) defines patient-centered medical homes as a mode of care that includes personal physicians or other primary care providers, whole person orientation; coordinated and integrated care; safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements; expanded access to care; and payment that recognizes added value from additional components of patient-centered care.

Notably, Section 3502(c)(2)(A) had initially specified only “personal physicians,” but was amended by Section 10321 to include “other primary care providers” as well.

Recommendations:

- **Regulatory: Implementing regulations or policy should specify that community health teams will be used to support APRN-led patient-centered medical homes, consistent with Section 3502(c)(2)(A).**

2. Medicaid health homes

Background: ACA Section 2703 gives states the option to establish “health homes” to provide services to Medicaid recipients with chronic conditions. To be eligible for health home services, an individual must be Medicaid-eligible and (a) have at least two chronic conditions; or (b) have one chronic condition and be at risk for a second; or (c) have a serious and persistent mental health condition.

Health homes must provide comprehensive and timely high-quality services, including comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services.

A health home may be a designated provider, a team of health care professionals operating with such a provider, or a health team. A “designated provider” is a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider determined by the State and approved by the Secretary.

A “team of health care professionals” may “include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State.” It may be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary. A “health team” is one that meets the specifications of ACA Section 3502 (discussed immediately above).

Payment for health home services may be tiered to reflect the severity or number of each individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team. The term “specific capabilities” is not defined.

Recommendations:

- **Regulatory: Fund qualified APRN practices as eligible Medicaid health homes.**
- **Ensure that APRNs and other RNs are members and leaders of the “team of health care professionals.”**
- **Providing “tiered” payment “to reflect ... the specific capabilities of the provider, team of health care professionals or health team” must not include paying APRNs as a group at lower rates than other providers.**

C. Accountable care organizations and pediatric accountable care organizations

1. Accountable care organizations

Background: ACA Section 3022 (modified by Section 10307) establishes the Medicare Shared Savings Program. This program, which is to be established by January 1, 2012, encourages the formation of accountable care organizations (ACOs) to manage and coordinate care for fee-for-service Medicare beneficiaries. ACOs are accountable for the quality, cost, and overall care of the Medicare beneficiaries assigned to it. ACOs that achieve benchmarks for quality and cost-savings share those savings.

ACOs will be formed through various arrangements between ACO professionals¹⁵, hospitals, other service providers and/or suppliers. Section 3022 provides examples of these arrangements, but gives the Secretary flexibility in determining what will qualify as an ACO. Section 10307 also adds considerable flexibility in payment models to be utilized, including partial capitation arrangements and “any payment model that the Secretary determines will improve the quality and efficiency of items and services” provided to Medicare beneficiaries.

Each ACO must be structured to receive and distribute payments for shared savings to participating providers and suppliers. It must also include sufficient numbers of primary care ACO professionals to serve the Medicare beneficiaries assigned to it. Each ACO will have at least 5,000 beneficiaries.

Each ACO must demonstrate that it meets patient-centeredness criteria specified by the Secretary. The Secretary will determine measures to assess the quality of care furnished by the ACO, specify data reporting requirements and establish quality performance standards for ACOs. The Secretary may also incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI)¹⁶.

Recommendations:

- **Regulatory:** Ensure that APRNs, in addition to qualifying as ACO professionals, may create provider groups or networks to form and participate in ACOs.
- **Regulatory:** No physician direction of ACOs or supervision of APRN practice groups involved in ACOs should be required.
- **Regulatory:** Encourage the formation of ACOs in which APRNs serve as providers in partnership with hospitals or other institutions— APRNs are not to be limited to roles as employees of physician groups or hospitals.
- **Make technical assistance available to small practice groups, particularly those formed by APRNs or other non-physician groups.**
- **The flexibility given to the Secretary in determining ACO arrangements and payment models should allow for formation of ACOs involving smaller or**

¹⁵ “ACO professionals” are physicians and practitioners as defined in Section 1842(b)(18)(C)(i) of the Social Security Act. This includes NPs, CNSs, CRNAs and CNMs, as well as physician assistants, clinical social workers, clinical psychologists and registered dietitians or nutrition professionals.

¹⁶ Note that NPs, CNSs, CNMs and CRNAs are eligible providers under the PQRI.

more focused practice groups, providing greater opportunities for APRN groups to participate in the Medicare Shared Savings Program.

2. Pediatric accountable care organizations

Background: Section 2706 of ACA establishes a demonstration program under which states may authorize payment to pediatric accountable care organizations, similar to the ACO demonstration project but centered on pediatric patients (and geared toward the Medicaid and CHIP programs). Under the program, the Secretary may authorize a participating State to allow “pediatric medical providers that meet specified requirements” to be recognized as an ACO for purposes of receiving incentive payments. This provision does not specify whether “pediatric medical providers” will include APRNs.

Recommendation:

- **Regulatory: Recognize that APRNs who provide services to children (including pediatric NPs and family NPs) are “pediatric medical providers” eligible to be pediatric accountable care organizations.**

V. QUALITY OF CARE INITIATIVES

A. Health care delivery system research

Background: ACA Section 3501 adds Sections 933 and 934 to the Public Health Service Act. Section 933 calls for identifying, developing, disseminating and providing training in best practices in health care quality, safety and value. The AHRQ Center for Quality Improvement and Patient Safety is responsible for implementing a model to pursue research in these areas in collaboration with other federal agencies. The Center is to utilize “research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics.”

Among its functions is to “provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children’s health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care service.”

The Center will also support communication and translation of research findings into practice recommendations in a number of specified areas. The Director of AHRQ will identify and regularly update a list of processes or systems on which to focus research, taking into account several factors (one of which is “provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce.”

AHRQ has a significant history of funding research on nursing care quality. This program provides important opportunities for funding and utilizing research on nursing's contributions to health care quality, safety and efficiency.

Recommendations:

- ***Regulatory:* Ensure that funding, dissemination and utilization of research on nursing's contributions to patient safety are among the priorities for this program.**
- **Ensure continued roles for nursing in advising on the Center's work.**
- **Seek input from nursing experts regarding research on provider assessment health care processes and systems and on opportunities to minimize distress and injury to the health care workforce.**

1. Adult health quality measures

Background: Section 2701 of the ACA adds Section 1139B to the Social Security Act, requiring the Secretary to identify and publish a recommended core set of adult health quality measures for Medicaid-eligible adults. These adult measures are intended to parallel the core set of child health quality measures required by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (and contained at SSA Section 1139A).

A recommended initial core set of adult health quality measures for Medicaid eligible adults are to be published for comment by January 1, 2011; a final initial core set of measures is to be published by January 1, 2012, by which time the Secretary will also establish a Medicaid Quality Measurement Program. Starting in 2014, that program will publish annual recommended changes to the initial core set of measures. By January 1, 2013, the Secretary (in consultation with the States) is to develop a standardized format for reporting information based on these measures and create procedures to encourage States to use the measures for voluntarily reporting.

Among the provisions of SSA Section 1139A regarding the development of pediatric health care quality measures, which this new section parallels, is a requirement that, in identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with a number of groups, including pediatricians and other primary and specialized pediatric health care professionals (including "members of the allied health professions") who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs; national organizations and individuals with expertise in pediatric health quality measurement; and organizations involved in the advancement of evidence-based measures of health care.

Recommendations:

- ***Regulatory:* Nurses, including APRNs, nursing experts on health quality measurement, and nursing organizations must be included among groups with whom the Secretary consults on development, utilization and revision of adult health quality core measures.**

2. Patient-centered outcomes research

Background: Section 6301 of the ACA establishes a Patient Centered Outcomes Research Institute (PCORI) responsible for identifying, planning and implementing comparative clinical effectiveness research. Comparative clinical effectiveness research is research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of two or more medical treatments, services, and items, including health care interventions, treatment protocols, care management and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals, integrative health practices, and any other strategies or items being used to treat, manage, diagnose or prevent illness or injury in individuals.

The PCORI will be established as an independent corporation overseen by a board of governors, which will include the directors of AHRQ and NIH (or designees), plus 17 members appointed by the U.S. Comptroller General. The statute lists the required affiliations of members; among these are “five members representing physicians and providers, including at least one surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.” (There are other categories that might include nurses as appointees, including three members representing patients and health care consumers and one member representing quality improvement independent health service researchers).

The PCORI may appoint permanent or ad hoc expert advisory panels to assist in identifying research priorities and establishing its research project agenda. It will also appoint expert advisory panels on randomized clinical trials and on rare diseases. These expert advisory panels are to include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based health care who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies.

The PCORI will also establish a standing methodology committee to be composed of the Directors of AHRQ and NIH (or designees), plus no more than 15 members to be appointed by the U.S. Comptroller General. These appointees will be experts in health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies.

Recommendation:

- ***Appointment:* Include nurses on the PCORI Board of Governors (which, by statute, must include at least one nurse) and the methodology committee and on expert advisory panels.**

VI. EXPANDING NURSE MANAGED HEALTH CLINICS AND FQHCs

Background: Current Section 330 of the Public Health Service Act sets out requirements for federally qualified health centers (FQHCs). Section 5208 of ACA adds a new Section 330A to the Public Health Service Act to provide funding for Nurse Managed Health Clinics (NMHC). In addition, Section 5601 of the ACA provides for greatly expanded funding for FQHCs.

Under the new Section 330A of the Public Health Service Act, an NMHC is “a nurse-practice arrangement, managed by APRNs, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.” To qualify for funding, the NMHC must submit an application providing assurances that nurses are the major providers of services at the NMHC and that at least one APRN holds an executive management position within the NMHC; assurances that, during the grant period, it will continue providing comprehensive primary care services or wellness services without regard to income or insurance status; and assurances that it will establish a community advisory committee, of which a majority are individuals served by the NMHC.

Section 5208 authorizes \$50,000,000 for fiscal year 2010, “and such sums as may be necessary for each of the fiscal years 2011 through 2014.”¹⁷ This section is, of course, an important provision that can greatly contribute to expanded access to primary care and other health services delivered by APRNs and other members of an interdisciplinary team if they are adequately funded. NMHCs are safety-net providers and need to be supported as such.

Because most nurse-managed health clinics are operated by schools of nursing, they cannot meet the community governance requirements of the FQHC program (most nurse-managed health clinics are legally controlled by their parent universities Boards. The federal government makes available to FQHCs a broad array of services and funding that promote sustainability. When nurse-managed health clinics do not have access to these services, it makes it harder for them to serve uninsured patients while remaining fiscally stable.

Another example of an opportunity for the federal government to support nurse-managed health clinics in the same way it supports other safety net health centers can be found in Section 1311(c)(1)(C) of the Affordable Care Act. This section creates American Health Benefit Exchanges that will facilitate enrollment in qualified health plans in each state. For a plan to be a qualified health plan under an Exchange, it must include within its provider network “essential community providers.” The language of the Affordable Care Act explicitly includes FQHCs and other types of community-based clinics in the definition of “essential community provider.” Requiring all of the qualified plans in the Exchanges to include nurse-managed health clinics in their networks as essential community providers would help address the problem of inadequate insurer recognition and reimbursement facing many nurse-led safety net practices.

Recommendations:

- ***Budget: Authorize and ensure adequate annual funding for NMHCs to expand access to this much-needed source of primary care services.***

¹⁷ In June 2010, Secretary Sebelius announced \$15,000,000 from the Prevention and Public Health Fund to be used for funding 10 nurse-managed health centers.

- **Regulatory: Include NMHCs in the regulatory definition of “essential community provider” found in Section 1311(c)(1)(C) of the Affordable Care Act .**
- **Legislative: Ensure that NMHCs have access to the enhanced reimbursement and other resources currently available to FQHCs.**

VII. IMPROVING NON-HOSPITAL CARE FOR SENIORS

A. Independence at home demonstration programs

Background: Section 3024 of the ACA establishes the Independence at Home Demonstration Program for chronically ill Medicare beneficiaries. The program, which is to start by January 1, 2012, will test payment incentives and service delivery systems that utilize home-based, physician and nurse practitioner directed primary care teams to reduce expenditures and improve health outcomes. The program seeks to reduce preventable hospitalizations, prevent hospital readmissions, reduce emergency room visits, improve health outcomes, improve the efficiency of care, reduce the cost of Medicare services, and achieve beneficiary and family caregiver satisfaction.

The Secretary will set per-capita spending targets for Medicare beneficiaries participating in the program. Independence at home medical practices that achieve cost savings will be eligible for incentive payments based on those savings.

Subsection (b)(1) of the new Social Security Act Section 1866D describes eligible practices. It reads as follows:

- (A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal entity that—
- (i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary’s chronic conditions and designed to achieve the results in subsection (a) [noted above];
 - (ii) is organized at least in part for the purpose of providing physicians’ services;
 - (iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;
 - (iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;
 - (v) has entered into an agreement with the Secretary;
 - (vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and
 - (vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The program is limited to 10,000 independence at home medical practices. An agreement with a practice may cover not more than a 3-year period.

According to the statute, “the term ‘physician’ includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be

made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i)." The statute also provides that "[n]othing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice" if other requirements of the program are met; the NP or PA is acting consistent with state law and has the "medical training or experience" to fulfill the NP or PA role described in paragraph (1)(A)(i).

The definition of "physician" appears to be intended to clarify that "physicians' services," as used in this section, include services provided by NPs and PAs. "Physicians' services" is often used as a term of art in Medicare, referring to professional services provided under Part B. Medicare law authorizing payment for NP, PA, CNS and CNM services does so by defining each when each are considered "physicians' services." The subsequent reference to "medical training or experience" should be interpreted broadly, given its context.

Recommendations:

- ***Regulatory:* Ensure that APRN practices are included among the practices participating in this program**

B. Transitional care

Background: Section 3026 of the ACA creates a Community-Based Care Transitions Program to provide funding to eligible hospitals and community-based organizations that provide improved care transition services to high-risk Medicare beneficiaries. Such programs seek to prevent hospital readmissions for patients with chronic conditions. This provision is widely acknowledged to expand in part on the work of Mary Naylor, PhD, RN, FAAN of the University of Pennsylvania. The model developed by Dr. Naylor emphasizes the role of APRNs.

ACA Section 3026 does not specify the use of any particular model of transitional care, nor does it require the use of any particular type of provider.

Recommendation:

- ***Regulatory:* Selection criteria must ensure that APRN-led models are well represented among entities participating in the Community-Based Care Transitions Program.**

C. Home health care and durable medical equipment

Background: Under Section 6407, subsection (A) of the ACA, a physician must conduct a face-to-face encounter with a patient prior to certifying the patient for Medicare or Medicaid home health services. Section 10605 amends this requirement by allowing an NP or a CNS "who is working in collaboration with the physician in accordance with State law" to conduct the face-to-face encounter on behalf of the physician. This encounter may also be conducted by a CNM "as authorized by State law" (no collaboration requirement is specified) or a PA under physician supervision.

Note that this provision does not authorize APRNs (or PAs) to certify patients for home health agency services or to order home health services or DME¹⁸. It allows them to conduct the face-to-face encounter on the physician's behalf. When the encounter is conducted by an NP, CNS or PA, the physician must attest to the fact.

In addition, Section 6407, subsection (B) requires that orders for Durable Medical Equipment (DME) "be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist...has had a face-to-face encounter...with the individual involved." Current Medicare policies permit NPs and CNSs to order DME¹⁹. Where a face-to-face examination is currently required under Medicare rules, the NP or CNS may conduct this; not physician documentation of the encounter is required²⁰. Thus, the ACA's requirements for physician documentation of a face-to-face encounter by a physician, NP, CNS, or PA prior to ordering DMA adds new and unnecessary restrictions to current regulatory practice.

These requirements for physician attestation that another clinician conducted the face-to-face encounter for home health certification or ordering DME are unnecessary and appear to question the integrity of these clinicians; the clinician's own attestation that he or she conducted the encounter should be sufficient. These requirements also can impede the efficient delivery of care and increase costs.

Recommendations:

- ***Legislative:* Support legislative efforts to authorize APRNs to certify patients for home health services and to order home health services under Medicare and Medicaid.**
- ***Legislative and Regulatory:* Maintain current regulatory policies authorizing APRNs to order DME.**
- ***Legislative and Regulatory:* Authorize APRNs to conduct face-to-face encounters required for certifying for home health services and ordering DME without requiring physician documentation of the face-to-face.**

VIII. NEW FEDERAL COMMISSIONS AND ADVISORY BODIES

PPACA establishes a number of commissions and advisory boards. Among them are:

- Section 1322: Advisory Board to the Consumer Operated and Oriented Plan (CO-OP) Program (15 members appointed by U.S. Comptroller General; appointments were announced on June 23, 2010).

¹⁸ ACA Section 3108 amends Section 1814(a) of the Social Security Act to authorize PAs to order post-hospital extended care services. NPs and CNSs are already authorized to order these services under Section 1814(a).

¹⁹ See, for example, CMS (2008), *Medicare Program Integrity Manual, Chapter 5, Section 5.5 (Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and CMNs)*.

²⁰ See 42 CFR 410.38.

- Section 2022: Advisory Board on Elder Abuse, Neglect and Exploitation (27 members, appointed by the Secretary; a call for nominations was issued on July 9, 2010 and ended on August 15, 2010).
- Section 2951: Advisory Panel for Maternal, Infant and Childhood Home Visiting Programs (appointed by the Secretary to provide recommendations on technical assistance for process improvement)
- Section 3403, modified by Section 10320: Independent Medicare Advisory Board (IMAB, subsequently renamed the Independent Payment Advisory Board [IPAB]) 15 members appointed by the President, majority not involved in provision or management of Medicare services or supplies).
- Section 3403: Consumer Advisory Council to the IPAB (10 consumer members appointed by the U.S. Comptroller General)
- Section 4305: Interagency Pain Research Coordinating Committee (appointed by the Secretary; includes 12 non-Federal members, of whom six are to be “appointed from among scientists, physicians, and other health professionals.”)
- Section 5101: National Health Care Workforce Commission (15 Members appointed by the U.S. Comptroller general, majority not involved in health care professional education or practice).
- Section 6301: Patient Centered Outcomes Research Institute (PCORI) Governing Board (17 members appointed by U.S. Comptroller general)
 - PCORI expert advisory panels (appointed by the PCORI)
 - PCORI standing committee on methodology (appointed by the U.S. Comptroller General)
- Section 8001: CLASS Independence Fund Board of Trustees (15 members appointed by the President, a majority of whom represent individuals who participate or are likely to participate in the CLASS program)
 - Personal Care Attendants Workforce Advisory Panel (appointed by the Secretary)

Recommendations:

- ***Appointments:* Appoint nurses with relevant expertise and other qualifications to a broad variety of federal advisory commissions and panels.**