

March 1, 2019

The Honorable Lamar Alexander, Chairman  
The Honorable Patty Murray, Ranking Member  
The United States Senate Committee on Health, Education, Labor and Pensions  
428 Dirksen Senate Office Building  
Washington, DC 20515

**RE: Recommendations on Lowering Health Care Costs**

Dear Chairman Alexander and Ranking Member Murray:

The American Nurses Association (ANA) is pleased to provide comments in response to the December 11, 2018 letter from the United States Senate Committee on Health, Education, Labor and Pensions (HELP Committee) soliciting feedback on controlling America's rising health care costs. The HELP Committee requested comments on steps Congress can take to address America's rising health care costs and recommendations that Congress can make to the Trump Administration and state governments that incentivize care that improves the health and outcomes of patients and increase the ability for patients to access information about their care to make informed decisions. ANA strongly believes that an expansion of the role that Registered Nurses (RNs) play in care coordination in both Medicare and Medicaid represents a major opportunity for this country to slow health care costs and improve patient outcomes.

ANA is the premier organization representing the interests of the nation's 4 million registered nurses (RNs) through its constituent and state nurses associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include those practicing in the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.<sup>1</sup> ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

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<sup>1</sup> The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Reducing the rate of growth in health care spending is a critical issue; and improving patient outcomes is a critical component of reducing the growth in health care spending. The *National Health Expenditure Projections 2018-2027* released in February 2019 project that under current law and known factors, national health spending is projected to grow at an average rate of 5.5 percent per year for 2018-2027, and that national health spending is projected to grow 0.8 percentage point faster than Gross Domestic Product (GDP) per year over the same period, meaning that health spending will consume an ever larger portion of overall domestic spending (roughly one-fifth by 2027). Demographic changes are anticipated to be the major drivers of these trends, particularly the aging population of Baby Boomers entering the Medicare program – which is projected to experience average annual spending growth of 7.4 percent for 2018-2027; the Medicaid program is projected to experience average annual spending growth of 5.5 percent. The combined projected spending growth in these programs is anticipated to increase the share of health care spending sponsored by federal, state, and local governments to 47 percent by 2027 (an increase of 2 percentage points over the projection period).<sup>2</sup>

It is for these reasons that ANA believes that care coordination is a key area in which RNs play a crucial role in lowering health care costs and improving patient outcomes. ANA recognizes and promotes the integral role of RNs in the care coordination process to improve health care consumers' care quality and outcomes across patient populations and health care settings, while stewarding the efficient and effective use of health care resources. Patient-centered care coordination is a core professional standard and competency for all RN practice. Based on a partnership guided by the health care consumer's and family's needs and preferences, the RN is integral to patient care quality, satisfaction, and the effective and efficient use of health care resources. Registered nurses are qualified and educated for the role of care coordination, especially with high risk and vulnerable populations<sup>3</sup>, including those with a large number of providers to treat the complex chronic conditions (of note as a large segment of the population ages into the Medicare program).

In partnership with other healthcare professionals, RNs have demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care coordination processes and models. The contributions of RNs performing care coordination services must be defined, measured and reported to ensure appropriate financial and systemic incentives for the professional care coordination role. Given the acute (and increasing) shortage of primary care providers in the U.S. – particularly in

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<sup>2</sup> U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. *National Health Expenditure Projections 2018-2027*. February 2019. Web: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf>

<sup>3</sup> American Nurses Association. *ANA Official Position Statement: Care Coordination and Registered Nurses' Essential Role*. June 2012. Web: <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/care-coordination-and-registered-nurses-essential-role/>

rural and underserved areas – the importance of the RN in care coordination will only increase in the near term.<sup>4</sup> ANA urges the HELP Committee to work in tandem with ANA, the Centers for Medicare & Medicaid Services (CMS), and the Center for Medicare & Medicaid Innovation (CMMI) to develop and implement new care coordination models and to improve and expand existing care coordination models, in both the Medicare and Medicaid programs and with private payers, that define and emphasize the role of RNs in care coordination.

### **Care Coordination Models Established through CMMI**

CMMI has implemented and studied several care coordination models, including: Comprehensive Primary Care Initiative (CPCI); the Comprehensive Primary Care (CPC) +; the Oncology Care Model (OCM); the Bundled Payment for Care Initiative (BCPI); and the Comprehensive Care for Joint Replacement (CJR) and Episode Payment Models (EPM). These models provide templates to strengthen primary care provision and incentivize care coordination. ANA believes that these models – and the development and implementation of similar models – showcase the important role that RNs play in primary care and care coordination. The CPCI and OCM models in particular present valuable opportunities to leverage the care coordination expertise of RNs:

- **Comprehensive Primary Care Initiative (CPCI)**: CPCI was a four-year multi-payer initiative designed to strengthen primary care. The initiative tested whether population-based care management fees and shared savings opportunities supported by multiple payers can achieve improved care, better health for populations, and lower costs. The program began in 2012 and was 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 received monthly fees from other participating CPCI payers and were expected to combine CPCI revenues across payers to develop a whole-practice transformation strategy. In its first year, CPCI achieved gross savings and was nearly cost neutral, with positive quality results.

CPCI provided an opportunity for the involvement of nurses in care coordination. Indeed, Mathematica Policy Research indicated in its 3<sup>rd</sup> 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

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<sup>4</sup> Bauer, Laurie, et al. *Expanded Roles of Registered Nurses in Primary Care Delivery of the Future*. Nursing Outlook, Volume 65, Issue 5, 624-632. Web: <https://www.sciencedirect.com/science/article/abs/pii/S0029655416302391>

care plan development.”<sup>5</sup> The Mathematica report further indicated that nurses were used as on-call staff to triage patient issues after hours and address patient needs by telephone.<sup>6</sup>

- **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 Fee-for-Service (FFS) beneficiaries receiving chemotherapy treatment and includes the spectrum of care provided to a patient during a six-month episode that begins with chemotherapy. OCM is a five-year model that began on July 1, 2016 and runs through June 30, 2021.

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 and 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 their 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

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<sup>5</sup> Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report, Mathematica Policy Research, December, 2016, page 74.

<sup>6</sup> Mathematica, page 100.

- Providing access to additional patient resources, such as emotional support groups, pain management services, and clinical trials.

ANA strongly believes that building on the successes of the CPCI and OCM models and developing similar models that employ the care coordination expertise of RNs will contribute to reducing growth in health care costs and improving patient outcomes.

### **CMMI and Section 1115A Demonstration Waiver Authority**

ANA also encourages the HELP Committee to work with ANA and CMS/CMMI to develop and implement care coordination demonstration models under the statutory waiver authority granted under Section 1115A of the Social Security Act (authority granted under Section 3021 of the Affordable Care 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 health care 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.

ANA specifically encourages the HELP Committee to explore demonstration models that would allow for the direct payment of RNs for care coordination services. Such demonstration models would not be unprecedented. CMS created the Medicare Diabetes Prevention Program (MDPP) under the same authority; through this program, CMS pays CDC accredited diabetes prevention programs which 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.

### **Medicaid and Care Coordination**

ANA also encourages the HELP Committee to work with ANA, CMS, state Medicaid programs, and other Medicaid entities (e.g., managed care organizations and community health providers) to establish a definition of care coordination within the Medicaid program and to ensure that RNs have a central role

with respect to that definition. There is currently neither a statutory nor regulatory definition of care coordination for the Medicaid program at the federal level (though there is a definition of case management). A single definition of care coordination at the federal level is critical to ensure that state Medicaid programs apply the term in an equitable manner; however, such a definition must also be broad enough to ensure that states maintain the traditional flexibility inherent in each state's program. A 2007 Agency for Healthcare Research and Quality (AHRQ) review found over 40 different definitions for care coordination activities.<sup>7</sup> This AHRQ study utilized common elements of these care coordination activities to develop the following definition:

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

RNs are a crucial part of the multidisciplinary care coordination team, and any statutory or regulatory definition of care coordination should reflect that.

Finally, ANA encourages the HELP Committee to work with ANA and CMS to continue to evaluate and promote the role of Health Homes – created under Section 2703 of the Affordable Care Act to coordinate care for people with Medicaid who have chronic conditions – in care coordination, and specifically to evaluate and promote the role of RNs in the operation of Health Homes.

An evaluation of the first 11 states to implement Health Homes found that care coordination improved using multidisciplinary care teams and that Health Homes show promise in effectively addressing needs of individuals with complex chronic physical and mental conditions and substance use disorder, particularly those who also have high social needs.<sup>8</sup> Given the role of the RN in interdisciplinary care teams and the high care costs of individuals with complex

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<sup>7</sup> Agency for Healthcare Research and Quality. Care Coordination, Quality Improvement. Content last reviewed October 2014. Rockville, MD. Web: <http://www.ahrq.gov/research/findings/evidence-based-reports/caregapt.html>

<sup>8</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. *Report to Congress on the Medicaid Health Home State Plan Option*. May 2018. Web: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/medicaidhomehealthstateplanoptionrtc.pdf>



chronic conditions, RNs in Health Homes represent a clear opportunity to reduce health care costs and improve patient outcomes.

We look forward to the opportunity to further engage with the HELP Committee regarding strategies to expand the role of RNs in care coordination. If you have questions, please contact Ingrida Lusi, Vice-President, Policy and Government Affairs ([Ingrid.Lusi@ana.org](mailto:Ingrid.Lusi@ana.org) or (301) 628-5081).

Sincerely,



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