

July 30, 2013

Hon. Fred Upton
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Hon. Henry Waxman
Ranking Member
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Hon. Joe Pitts
Chairman
House Energy & Commerce
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

Hon. Frank Pallone
Ranking Member
House Energy & Commerce
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

RE: Views of Advanced Practice Registered Nursing Organizations on the Medicare Patient Access and Quality Improvement Act of 2013 (HR 2810)

Dear Chairmen Upton and Pitts, and Ranking Members Waxman and Pallone:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs), we express our support for continued legislative progress on bipartisan legislation (HR 2810) repealing the Medicare sustainable growth rate (SGR) formula and reforming Medicare Part B payment, and urge its continued improvement.

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

We support the bill's replacing SGR cuts with a positive 0.5 percent update for each of the next five years. We also support its provisions developing, improving and refining quality measurement, incentive payment, and alternative payment systems through open and publicly accountable processes that treat APRNs the same as physicians when the same service is provided. The legislation includes specific provisions addressing the four principles we expressed to the Committee in our June 10 letter, in which we commented that Congress (a) direct that APRNs be made full partners in the development, use and evaluation of quality measures, including measures used for Medicare payment and incentives; (b) ensure that measures evaluate the work being done by the provider who is performing the service; (c)

require that the infrastructure for reporting be accessible and transparent; and (d) ensure that the development and implementation of alternative payment systems involves and recognizes APRNs in the same manner as physicians are recognized.

Improvements should be made to the legislation where it departs from the general federalism principle of deferring to states on APRN scope of practice. In particular, its patient-centered medical home provision constraining coverage of complex care management services solely to allopathic and osteopathic physicians (Sec. 4) should be amended to cover those services when they are provided by APRNs, as they are provided today. Without this change, chronically ill patients whose primary healthcare providers are APRNs will continue to be denied Medicare coverage of the very care coordination services that the peer-reviewed evidence links to improvements in patient quality of life, healthcare quality improvement, and cost savings. The legislation should also further ensure that it defines “eligible professional organizations” charged with identifying and evaluating clinical improvement activities and other services associated with quality improvement, incentive payments and alternative payment systems, to include those representing APRNs. In addition, to the extent that the legislation relates participation in registries to Medicare payment, registries must be developed, governed, and opened to any provider who would wish to participate in them and on equal terms with all other providers and provider types. Registries that influence Medicare quality payment incentives or adjustments must not protect guilds and anticompetitive practices, especially where more than one provider or physician type is known to provide services appropriate to a certain registry.

We look forward to continuing to work with you and your colleagues to move HR 2810 through the legislative process, to continue refining its technical and fiscal aspects, and to oppose amendments that would increase costs and reduce choice by impairing patient access to APRNs or constraining their full scope of practice. We remain at your service, and would be happy to answer questions. Please direct them to Frank Purcell of the American Association of Nurse Anesthetists, 202-741-9080, fpurcell@aanadc.com, and thank you.

Sincerely,

American Association of Colleges of Nursing, AACN

American Association of Nurse Anesthetists, AANA

American Association of Nurse Practitioners, AANP

American College of Nurse-Midwives, ACNM

American Nurses Association, ANA

Gerontological Advanced Practice Nurses Association, GAPNA

National Association of Clinical Nurse Specialists, NACNS

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

National Organization of Nurse Practitioner Faculties, NONPF

National Association of Pediatric Nurse Practitioners, NAPNAP