

## **ANA Comments to FTC with respect to Health Care Competition**

The American Nurses Association (ANA) welcomes the opportunity to provide comments to the Federal Trade Commission (FTC) on its' recent public workshop "Examining Health Care Competition." As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to represent its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members also include advanced practice registered nurses (APRNs) such as nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs).

ANA applauds the FTC on the publication of "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses," which builds on the FTC state level competition advocacy comments regarding proposed legislation that restricts access to APRN practice and care. ANA supports the removal of barriers and discriminatory practices that interfere with full participation by APRNs in the health care delivery system. FTC's competition advocacy acknowledges that mandatory physician supervision requirements restrict consumer access to high quality, cost effective APRN care.

ANA views the FTC "Policy Perspectives" as a very positive outcome of the 2010 Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*. The Future of Nursing report provides expert advice based on "[e]vidence suggest[ing] that access to quality care can be greatly expanded by increasing the use of . . . APRNs in primary, chronic, and transitional care," and expresses concern that scope of practice restrictions "have undermined the nursing profession's ability to provide and improve both general and advanced care." The report found that APRNs' scope of practice varies widely "for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work." The IOM report recognizes FTC competition advocacy in this area and specifically exhorted the FTC and the Antitrust Division of the U.S. Department of Justice to pay continued attention to the competition issues raised by scope of practice regulations.

ANA believes that every patient deserves access to safe, quality care from all healthcare providers. Health care is ever-changing and is currently undergoing a significant transformation. ANA supports initiatives which allow all members of the healthcare team to fully function consistent with their education and training in a cooperative manner. ANA encourages the FTC to continue its competition advocacy work in our transforming health care delivery system where overlapping patient care responsibilities between healthcare team members is the norm.

ANA encourages the FTC to continue its competition advocacy work as states propose legislation to implement the APRN Consensus Model. The APRN Consensus Model calls on states to license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision.

- **New Models of Health Care Delivery**

In response to the ever-changing health care environment, new health models for health care delivery create additional competition for health services. New health models such as retail health clinics, community paramedics, and telemedicine increase access to care and reduce costs.

### **Retail health clinics**

Due to national health reform, retail health clinics will play a larger role in providing basic preventive and primary care services. The most common reason families visit a retail health clinic include a new illness or unfamiliar symptom, vaccination, prescription renewal, a physical exam and ongoing care for a chronic condition.

Retail health clinics offer a valid alternative for individuals seeking health care services; especially in the light of the continuing shortage of primary care providers. Retail health clinics have been shown to combine quality, accessibility and affordability to those seeking services. Retail health clinics are filling a gap in health care services and may prevent unnecessary emergency department visits. As chronic health issues represent over 65% of all health care spending, retail health clinics are taking a leading role in the management of chronic conditions such as diabetes, and hypertension.

ANA supports the delivery of primary care and other health care services by NPs in retail-based health clinics. Peer-reviewed studies continue to add evidence confirming that NPs offer high quality care in the primary care setting. In addition to their education and expertise in diagnosis and treatment, NPs' proficiency in providing health education and prevention services makes them skilled managers and service providers in retail-based clinics. Retail-based clinics provide an additional innovative entry point for patients to access affordable, high-quality health care, thus helping to address some of the system's more pressing problems

In some states, requirements for physician supervision of NPs prevent retail clinics from entering the market. State regulations that include restrictive ratios for physician oversight are not genuinely evidence-based. For example, frequently referenced is a report from The American Academy of Family Physicians that asserted, "Research shows that the best care is achieved when the ratio of nurse practitioners to physicians is about 4-to-1." In fact, the cited reference is a document published more than twenty years ago regarding developing countries, where a ratio of four registered nurses per physician was concluded to be beneficial. There were no NPs or other APRNs involved in that research.

## **Telehealth**

Telehealth is not a new health care concept as it was initially created to care for individuals who lived in remote or difficult to reach areas. Telehealth has become more commonplace in urban settings such as home health agencies, primary care provider offices, workplaces, and patient's homes.

ANA encourages the use of the broader term "telehealth" rather than the more restrictive term "telemedicine" and encourages telehealth delivery models that utilize and reimburse RNs and APRNs and other health professionals. ANA encourages the FTC to expand competition advocacy to counter proposed state and federal regulations that only allow physicians to provide and be paid for telehealth services.

- **An informed public, interoperable health information systems, and improved efficiency**

Health information, as represented in electronic health records (EHRs), clinical decision support (CDS) solutions, computerized provider order entry (CPOE), and others, is an extremely important component of the modern health care system and is instrumental in the development of a national continuous rapid learning health care system (LHS). Unfortunately, the absence of interoperability standards within and among vendors' products, combined with significant customization of those products (away from the standard build) at the clinical point of care (e.g., adding site-specific order sets), prevents sharing of patient-centered health information vertically (from one care setting to another) or horizontally (among similar settings). This important information includes clinicians' notes, test results, patients' responses to treatment and education, and other important details. For instance, in a common patient transfer from a community hospital to an academic medical center for advanced care, much of the granular clinical data captured at the sending site is not readable at the receiving site. Even if both the community hospital and the academic medical center used the same brand of EHR, it is unlikely that much more than the transfer note and other legally required information would be interoperable. If the academic medical center used a different vendor's EHR solution, the likelihood of interoperability would be nil.

This lack of interoperability is among the reasons why care transitions require redundant data capture, are costly, laborious, and fraught with error. Standardized methods of data capture, limiting the use of bespoke order sets, and reducing the need for free-text (or demanding that systems improve the ability to convert free-text to standardized text) would improve the quality of care transitions. It would also improve overall data sharing for learning, while also improving nurse work enjoyment and patient outcomes.

The health care data marketplace supports the current paradigm of inadequate or non-existent health care data interoperability, because it places little value on data transfer in support of care transitions and care coordination. Further, the provision of health care by clinicians (e.g., physicians, nurses) at health care facilities (e.g., clinics, hospitals) follows a business model mostly paid for by third parties (e.g., insurance companies). This model does not incentivize clinicians to give excellent transitional care. Instead, they earn money for the care given at the point of service and nothing beyond that point. There is no incentive for patients, because many pay only a small proportion of the actual cost of services and few understand the value of excellent care coordination or transition. Payers have some incentive to improve care transitions, but have few tools through which to incentivize clinicians. Therefore, virtually no one would be willing to pay EHR vendors to create interoperable foundations. Without payment, EHR vendors have no incentive to do it, thus stifling innovations that could improve care coordination and transition, or the development and growth of a national LHS.

ANA believes that informed patients are the key to unlocking interoperability. Informed patients will demand that clinicians share their data with them and seamlessly among their other providers. In turn, clinicians in all settings would demand and pay EHR vendors to build interoperable systems. CMS took a first step in informing patients by releasing some of the cost data for clinician and hospital care. These cost and effectiveness data from payers, clinicians, and health care organizations could contribute to a public that is better informed and more effective in its overall management of its collective health care. Further, from these data the public can see how many resources the nation spends on inefficient information silos, redundant data collection, and incorrect data. Combined with evidence supporting improved data sharing, an informed public could demand interoperability, because it would recognize the value it would bring. FTC would benefit from monitoring these data to ensure fair business practices and competition.

- **Effects on competition of information related to quality of care**

The ANA supports the use of the appropriate mix of rigorous structural, process, and outcome quality measures that are effective tools in performance improvement through accountability. Accountability measures include measures for public reporting (e.g., Hospital Compare) and pay for quality. Such measures facilitate program evaluation to improve patient outcomes across all settings of care. Accountability core measures also include metrics to evaluate the care of vulnerable populations with the goal of reduction of disparities in care. These core sets of measures should include patient-centric, team-based measures for use within settings (e.g., hospitals), and when appropriate aligned for use across settings, payers, and for targeted populations in order to achieve the aims and goals of the National Quality Strategy (NQS). The ANA notes the importance of adding to the core measure sets key safety measures that are particularly important to vulnerable populations. For example, ANA requests CMS add the National Quality Forum (NQF)-endorsed ANA measures, nurse staffing (NQF #0205) and skill mix (NQF #0204) in national public reporting in Hospital Compare. Consumers understand the importance of these safety measures and are in favor of their addition given the evidence of reduced mortality and avoidable adverse events with higher levels of nurse staffing and skill mix.

The next generation of measures should evolve to include team-based shared accountability and attribution. The data collected from these measures will inform the best mix of clinicians and staffing to achieve the best outcomes for populations at risk to inform the future health systems, “learning health systems”. In addition, ANA supports the evolution of measures to eMeasures. To that end, ANA has developed and is piloting a de novo eMeasure of pressure ulcer incidence, ANA’s Pressure Ulcer Cumulative Incidence eMeasure (ePressUlcerCI). This innovation in measure development that collects clinical data, including nursing assessment data such as risk assessments, seamlessly from the electronic health record (EHR). This measure was presented to The IOM Committee on Core Metrics for Better Health at Lower Cost held on March 5, 2014.

In alignment with the NQS priorities, CMS has a particular interest in measures of continuity and coordination of care. ANA encouraged CMS to use measures that go beyond simple one-way handoff measures (e.g., specialist received consult: yes/no). Instead, measures should address the patient-centered outcomes of care coordination, as well as the processes, and structures upon which those outcomes depend. (Examples of such measures would include, respectively, outcome: patient attended follow-up appointment with eligible professional/specialist; process: patient selected eligible professional/specialist of choice based on his/her preferences; and structure: patient access to qualified workforce, such as interprofessional team with the competencies, skill mix, and staffing to deliver high quality patient-centered care). ANA convened a professional issues panel that developed an evidence-based measurement framework, ANA’s Framework to Measure Nurses Contribution to Care Coordination. This Framework has been disseminated widely for timely uptake in the National Quality Measurement Enterprise to inform prioritization of existing measures and identification of concepts for new measures to fill

the persistent measurement gaps. ANA has requested CMS use this Framework to inform new measure development.

CMS is instituting “Processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of the patient.” In future regulatory changes, ANA has recommended that CMS include within that attribution a breakout of all eligible professionals providing patient care within a given practice, within care settings, and across care settings. In addition, CMS ought to include other team-based licensed clinicians (e.g., RNs acting as care coordinators) whose practice is integral to providing the essential elements of patient/family centered, safe, effective, timely, equitable and efficient care.

PPACA §10331(d) requires CMS to obtain input from multiple stakeholder groups in selecting quality measures for Physician Compare. CMS data from calendar year 2011 indicate that 100,585 APRNs billing under their own NPIs provided covered services to 10.4 million Medicare fee-for-service beneficiaries. Those APRNs represented 9% of all eligible professionals in the program. ANA has offered to assist CMS in its mandated outreach through communication with its 30 Organizational Affiliate (OA) member organizations representing nursing specialties, 5 of which directly represent eligible professionals. ANA and its OA members can provide CMS with valuable information on what to measure and how to measure it. These insights can allow data reported on Physician Compare to best inform consumers of the highest quality of care available to them.

- **Competitive effects of price transparency**

With the exception of certain health care commodities (such as specific drugs) price transparency alone is virtually meaningless. Most health care services are rendered to patients as part of customized packages of services so the price of any single service may not matter very much. In fact, health care consumers want to know not only the services in the package, but also who is delivering the individual services and what will be their out-of-pocket costs for purchasing the package. What is needed is both price and product transparency.

The recent innovations in information offer some improvements over having no information, but again, they have tended to focus on a small number of prices. The Summary of Benefits and Coverage and Uniform Glossary mandated by the Affordable Care Act gives some examples of treatment packages, but that guide does warn that it is not a cost estimator. “Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.” In particular, two clinicians working in two different health plans might exhibit different average patient out-of-pocket costs because of the different clinician treatment preferences rather than different cost sharing rules. This could not be predicted examining the Summary of Benefits and Coverage for the two plans. For Medicare patients, the Summary of Benefits and Coverage may be even less revealing. Because of the use of the Medicare physician fee schedule, in any locality the individual Part B allowances for specific services are identical.

ANA and the nursing community have previously expressed concern that advanced practice registered nurses are set at a competitive disadvantage because of the restrictive practices of health insurers. Approximately half of all health insurance plans in the U.S. do not credential NPs and other APRNs into private health insurance networks. By not extending health insurance coverage to APRNs potential consumers who might want to secure such services would have to face higher out-of-pocket charges. Price transparency might not appear to be much of an issue if APRNs are not included in lists of network clinicians in the first place. Further, if APRNs in a particular State are only allowed to practice with a supervising or employer physician potential consumer advantages of possible lower prices or availability of “after-hours” practice may not be observed. In particular, a twentieth century physician billing practice known as “incident to” services can make APRN services invisible. Consumers who do receive clinical services from an APRN under such restrictions may find their bills implying that they had received a physician’s service billed at the physician price. In such cases, the physician practice appropriates the consumer surplus that might have been observed with direct APRN billing.

ANA has suggested to CMS the elimination of “incident to” billing for APRN services. “Incident to billing” not only can raise costs to consumers by charging the physician allowance, it also shields the identity of the APRN clinician whose services the consumer might want to secure independently. And it eliminates a chain of accountability that should follow the any performing clinician who directly provides a service to a patient. When it comes to the complicated services referred to by CMS, accountability demands that claims from a physician practice should specifically identify the performing clinician if that person is not the same as the billing clinician.

The IOM Future of Nursing report recommended that registered nurses everywhere in the U.S. should practice to the full extent of their education and training. To promote and ensure the access of privately insured (and Medicare and Medicaid) patients to the widest choice of competent, cost-effective health care providers, principles of equity would suggest that this patient choice should be promoted by policies ensuring that full, evidence-based practice is permitted to all providers regardless of geographic location. ANA has recommended to CMS that it has the responsibility to promulgate rules and policies that promote Medicare and Medicaid beneficiaries’ access to appropriate care, and therefore can ensure that its rules and policies reflect the evolving practice abilities of licensed providers. To the extent possible, FTC should also exert its authority to improve patient access to all qualified providers through private health insurance plans offered through either employment-based coverage or Affordable Care Act health insurance exchanges.

Although it may be somewhat outside of the purview of the FTC, the congressionally mandated differential between Medicare allowances for physicians and NPs and CNSs has a pernicious effect on the allowances observed in the private health insurance market. Among those private insurers who do credential APRNs into private health insurance networks, many claim to be bound by “federal regulations” to pay lower amounts to APRNs than they negotiate with

physicians, often much lower than the Medicare differential might imply. By refusing to negotiate on a level playing field, such insurers diminish the effective supply of primary care services and limit the competitive effects of allowing all qualified clinicians to participate in offering services to covered consumers.