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February 12, 2015

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Federal Trade Commission
600 Pennsylvania Avenue, NW
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Submitted electronically to: https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop

Re: FTC Public Workshop, "Examining Health Care Competition"

Dear Ms. Wilkinson:

On behalf of the American Nurses Association (ANA), we are pleased to offer our comments in advance of the Federal Trade Commission's (FTC) upcoming workshop entitled "*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 speak on behalf of 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 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.[1] ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[2]

ANA believes that every patient deserves access to safe, quality care from all health care providers. Health care is ever-changing and is currently undergoing a significant transformation. ANA supports initiatives which allow all members of the health care team to fully function consistent with their education and training in a cooperative manner.

ANA applauds the FTC's ongoing work to address competition in the health care market, including the March, 2014 publication, "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.

[1] http://www.bls.gov/ooh/healthcare/registered-nurse.htm.
[2] The Consensus Model for APRN Regulation defines four APRN roles: certified registered nurse anesthetist; certified nurse-midwife; clinical nurse specialist; certified nurse practitioner. 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.

The FTC "Policy Perspectives" document builds on the 2010 Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health,* which describes expert advice suggesting that increased utilization of APRNs in primary, chronic, and transitional care can expand access to quality care. The report also expresses concern that scope of practice restrictions undermines the ability of the nursing profession to provide general and advanced care, and that such variations are related to political decisions rather than ability, education or training, or safety concerns. The IOM report also recognizes FTC's competition advocacy and calls on the FTC and the Antitrust Division of the U.S. Department of Justice to continue focusing on competition issues raised by scope of practice regulations. ANA encourages the FTC to continue its competition advocacy work on this important issue.

Network Adequacy

One topic for the upcoming workshop is trends in provider network and benefit design strategies. Network adequacy trends remain a significant issue for health care consumers seeking to access care from APRNs. Despite the documentation of high quality services and high patient satisfaction with APRNs, private health insurers have not made significant steps to include them in private health insurance networks. Tine Hansen-Turton and colleagues from the National Nursing Centers Consortium have conducted repeated studies of the credentialing behavior of private health insurers. They reported managed care organization (MCO) credentialing rates for NPs of 33% in 2005[3] and 53% in 2007.[4] A more recent survey in this series focused on the credentialing policies of health maintenance organizations (HMOs) within managed care organizations during 2011-2012.[5] Seventy-four percent of HMOs with significant commercial product lines credentialed NPs as primary care providers. Those HMOs with significant Medicare or Medicaid product lines exhibit higher credentialing rates of 76% and 83%, respectively. This might be considered an improvement were it not for the fact that NP services are by law included in the benefit packages of Medicare and Medicaid. That one quarter of HMOs do not credential NPs is concerning, given the shortage of primary care providers in low income communities.[5]

The credentialing rate of another category of APRNs – certified nurse-midwives – is even lower. The American College of Nurse-Midwives (ACNM) recently completed a survey of marketplace insurers regarding coverage of midwifery services. Among their findings: 17% of plans do not cover primary care services offered by CNMs even though ACNM standards include primary care services, and 14% of plans indicated they impose restrictions on CNM practice more onerous than state laws and regulations.[6]

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[3] Hansen-Turton T, Ritter A, Begun H, Berkowitz SL, Rothman N, Valdez B. "Insurers' contracting policies on nurse practitioners as primary care providers: The current landscape and what needs to change" *Policy Politics & Nursing Practice* 2006; 7:216–226.
[4] Hansen-Turton T, Ritter A, Torgan R. "Insurers' contracting policies on nurse practitioners as primary care providers: Two years later" *Policy Politics & Nursing Practice* 2008; 9:241–248.
[5] Hansen-Turton T, Ware J, Bond L, Doria N, Cunningham P, "Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices" *Population Health Management*, 2013 Oct;16(5):306-9. doi: 10.1089/pop.2012.0107. Epub 2013 Mar 29.
[6] American College of Nurse Midwives News Release (September 18, 2014). Retrieved from: http://www midwife.org/acnm/files/ccLibraryFiles/Filename/000000004403/ACNMSurveyofHealthPlansReleaseFinalVersionforWebsite.pdf.

These data confirm long-held concerns of the nursing community: consumers are being denied the benefit of vigorous competition in the health care market. Today's attention to network adequacy provides an important opportunity to address these concerns. Network adequacy can have a significant impact on patient access to care. In narrow networks, patients may forgo care, experience a delay in receiving care, travel long distances to obtain care or be forced to pay to see providers outside of the network. This is an area where ongoing oversight by FTC could make a significant impact on access to health care.

Accountable Care Organizations/Medicare Shared Savings Programs

The Centers for Medicare and Medicaid Services (CMS) has recently proposed to revise the definition of an Accountable Care Organization (ACO) professional, and to take into consideration primary care services furnished by NPs, CNSs, and physician assistants (PAs) in its beneficiary assignment methodology.[7] While ANA supports the CMS proposal to revise the definition of ACO professional by removing the requirement that an ACO professional be an ACO provider/supplier, ANA recommended that CMS consider an ACO demonstration waiver that would also allow NPs and CNSs to become ACO participants, able as other ACO physician and hospital participants to share in the ACO's savings achieved during the demonstration.

APRNs have a long history of providing care to patients that leads to improved patient outcomes, increased access to care, enhanced patient safety, and greater cost savings. In addition to the direct provision of health care, APRNs play an integral role in managing and coordinating care for patients, particularly those with chronic disease, multiple co-morbid conditions, and other complexities. Care management and coordination are core tenets of accountable care and APRNs are essential to the foundational architecture of an ACO and its subsequent success in improving patient outcomes, enhancing the delivery and quality of care, and reducing costs. As such, given the breadth of APRNs' education and expertise, and in an effort to foster greater care coordination among ACO models, ANA has recommended that CMS reward – or otherwise encourage or incentivize – ACO entities that share their savings with APRNs. ANA recommends that FTC closely monitor this issue and encourage CMS to implement regulations that allow APRNs to share in the savings generated by ACOs.

Medical Homes

"Medical homes" have been identified as a way to increase access to quality care and control health care costs. A "medical home" is an approach to care that utilizes primary care providers to ensure the delivery of coordinated, comprehensive care.[8] The concept of the medical home has taken hold in many states as policy makers have looked for ways to improve care within the state Medicaid and Children's Health Insurance Programs (CHIP) programs.[9]

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[7] Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule (2014). http://www.gpo.gov/fdsys/pkg/FR-2014-12-08/pdf/2014-28388.pdf.

[8] There are a host of groups that have specifically defined the components of a medical home. For example, the Patient Centered Primary Care Collaborative (PCPCC) has offered a set of principles (http://pcpcc.net/content/joint-principles-patient-centered-medical-home) and the National Committee for Quality Assurance has created a program to recognize a patient-centered medical home.

[9] Kaye, N. and Takach, M. (2009). Building medical homes in state Medicaid and CHIP programs.

States can expand access to care by avoiding verbiage such as "physician-directed practice" and recognizing other certified Medicaid providers – such as NPs and CNMs – as leaders of a medical or health care home. The state of Washington answers the question of who can lead a medical home with the following: "A primary care provider (physician or nurse practitioner) leads the medical home with the support and direction of the patient, the patient's family, clinic staff, community agencies and other specialty care service providers."[10] ANA recommends that FTC continue to monitor the utilization of APRNs in medical homes, promote the use of provider neutral language by states, and advise against policies that refer exclusively to physicians or physician directed teams or practice.

ANA appreciates the opportunity to comment in advance of FTC's upcoming workshop. ANA and the nursing community stand ready to provide whatever assistance FTC may need in order to leverage nursing's unique contributions to the provision of direct patient care. If you have questions, please contact Peter McMenamin, ANA's Health Economist (peter.mcmenamin@ana.org or 301-628-5073).

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

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http://nashp.org/sites/default/files/building medical homes .emerging.states.pdf; Kaye, N., Buxbaum, J. and Takach, M. (2011). Building Medical Homes: Lessons from eight states with emerging programs. http://nashp.org/sites/default/files/building medical homes .emerging.states.pdf.

[10] Washington State Department of Health. Medical Home Key Messages. http://medicalhome.org/4Download/keymessages2007.pdf.