

April 23, 2024

The Hon. Ron Wyden  
Chairman  
Committee on Finance  
United States Senate  
219 Senate Dirksen Office Building  
Washington, DC 20510

The Hon. Mike Crapo  
Ranking Member  
Committee on Finance  
United States Senate  
219 Senate Dirksen Office Building  
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the American Nurses Association (ANA), I would like to thank you for holding the hearing, “Bolstering Chronic Care through Medicare Physician Payment,” on April 11, 2024. While physician payment has been discussed for decades, there also needs to be focus placed on how public payers such as Medicare ensure access to nursing care. The roles registered nurses (RN) and advanced practice registered nurses (APRN) play in health care delivery has changed significantly since the inception of the Medicare program.

ANA appreciates the Committee’s recognition that more fully valuing primary care providers is essential to helping the Medicare program better address chronic conditions. The shortage of primary care physicians in the United States is projected to be between 20,200 and 40,400 physicians by 2036.<sup>1</sup> Consequently, APRNs will be needed to fill this void in primary care, and they stand ready to be utilized to the fullest extent of their education and clinical training – Nurse Practitioners (NP), for example, already make up around 50 percent of the primary care workforce. Appropriately, Medicare rules and statements increasingly refer to Qualified Health Practitioners (QHP), in addition to physicians, in order to be more inclusive of APRNs. ANA would appreciate the Committee’s urging of the Centers for Medicare and Medicaid Services (CMS) to continue to do so. Moreover, RNs are significant providers of care coordination and related services that render team-based care effective for patients with chronic conditions. We appreciate this opportunity to share with you how several of our policy priorities align with the Committee’s goals for physician payment reform.

ANA is the premier organization representing the interests of the nation’s over 5 million registered nurses, 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 registered nurse roles: NPs, clinical nurse specialists (CNS), certified nurse-midwives (CNM), and certified registered nurse anesthetists (CRNA). ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

#### National Provider Identifier (NPI) Numbers for All Practitioners

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<sup>1</sup> <https://www.aamc.org/media/75231/download?attachment>

NPIs remain the gold standard for determining eligibility and reimbursing the health care clinicians for care provided to patients. RNs are integral parts of the health care team and spend significant time with patients providing clinical services. However, though they are eligible to receive them, NPIs are not required for RNs and they do not typically obtain them. In the current health care financing system, RN work is generally not accounted for, other than in the practice expense (PE) component of the relative value unit (RVU). The time spent by the RN is the main element of RN work that is captured in the PE of billing providers. *The lack of NPIs for nurses makes it extremely difficult to record, measure, and value the services they provide and their impact on patient outcomes.*

Obtaining an NPI is a first step to recognizing and evaluating the value of the nurse in the health care delivery system. Obtaining and recording RNs' NPIs in relevant health care data systems would allow health systems, payers, and enterprise resource planning systems to distinguish the value of nursing services from that of other providers. This would allow for a quantitative analysis and substantive demonstration of the nurse's role and value as an integral member of a patient's health care team. As such, ANA urges the Committee to explore utilization of the NPI for RNs as a means of better capturing the significant contributions of RN care. NPIs would not change RN reimbursement or pay as RN times and services provided are now included in the PE component of relative value unit RVUs.

#### Recognizing RN Value

As the Committee looks at ways to evolve and reform the health care system, ANA strongly advocates for changes in current reimbursement models to recognize the value of the nurse. The American Medical Association (AMA) created the CPT and RUC systems to value the work done by physicians and other qualified healthcare providers. While APRNs and other non-physician providers have NPIs and bill for services attributed to them, patient care provided by RNs is not billed and identified separately. The result is that RNs have historically been included as part of PE when the RUC either establishes or modifies the value of procedures in the CPT code set. However, this only captures the time it takes rather than fully capturing the scope of services that RNs provide to patients. Payment innovations centered on value should encompass the expertise of RNs and the clinical services they provide. As such, ANA encourages the Committee to explore reimbursement models that would capture the actual value of the RN as part of any broader Medicare payment reforms.

#### Incident To Billing

In the same vein as assigning NPI numbers to RNs, MedPAC has recommended for several years that Congress should require APRNs and physician assistants to bill the Medicare program directly, eliminating "incident to" billing for services they provide<sup>2</sup>. ANA agrees with MedPAC. Because of incident to billing, it is unknown what care is being delivered by physicians directly or by other practitioners. The data generated by eliminating incident to billing would give Congress and other policymakers a more complete understanding of how our health care system is working and will help uncover efficiencies and cost savings. Not only would eliminating incident to billing generate cost

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<sup>2</sup> <https://www.medpac.gov/recommendation/issues-in-medicare-beneficiaries-access-to-primary-care-5-1-june-2019/>

savings, but we believe the benefits of the data derived will provide significant value to policymakers, particularly with respect to appropriately valuing primary care.

#### Discounted Reimbursement for Nurse Practitioners and Clinical Nurse Specialists

Under current law, NPs and CNSs receive 85 percent of the physician fee schedule for the same work as their physician colleagues. In addition, only physicians receive a 10 percent bonus if they work in designated health professional shortage areas (HPSA), meaning NPs and CNSs receive less than 78 percent of the reimbursement as their physician colleagues for the same work in HPSAs. Furthermore, practice expenses do not change based on your professional designation. There is no reason the discounted reimbursement should include a discount on practice expenses when a difference between practice expenses of those of a physician and those of another qualified provider does not exist.

APRNs are educated under the nursing model, where clinical training is integrated into their core curriculum. APRN programs are competency-based, not time-based. A student must demonstrate mastery of content before advancing. While the nursing and medical models of training are different, the safety and quality of APRN competency-based education is consistently demonstrated in more than 40 years of patient care research. For example, the American Enterprise Institute released a report that found that “beneficiaries who received their primary care from NPs consistently received significantly higher-quality care than physicians’ patients in several respects. While beneficiaries treated by physicians received slightly better services in a few realms, the differences were marginal.”<sup>3</sup> ANA appreciates the Committee’s recognition of the need to bolster primary care in rural and underserved areas and expanding the 10% HPSA bonus eligibility for APRNs is a commonsense way to help address this growing challenge.

#### Improving Care and Access to Nurses (ICAN) Act (S. 2418/H.R. 2713)

ANA reiterates our staunch support for the ICAN Act, which contains a host of provisions that would increase access to cost-effective, high-quality care for Medicare and Medicaid beneficiaries. This legislation would increase patient access to care by removing outdated and unnecessary federal barriers on services provided by APRNs under the Medicare and Medicaid programs, further benefiting beneficiaries, especially those with chronic care conditions that must be closely monitored.

Recognizing the importance of APRNs to our health care workforce, and for patient access to care, the Institute of Medicine (IOM) issued *The Future of Nursing: Leading Change, Advancing Health* report in 2010, which called for the removal of laws, regulations, and policies that prevent APRNs from providing the full scope of health care services they are educated and trained to provide. In 2021, this position was reaffirmed by the National Academy of Medicine (previously named the IOM) in their 2021 *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*.

Unfortunately, there are still Medicare and Medicaid policies that have not been modernized to reflect the growing and essential role of APRNs. Various federal statutes and regulations remain which prevent APRNs from practicing to the full extent of their education and clinical training. Many of these policies were written before APRNs could participate in Medicare. These provisions reduce access to care,

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<sup>3</sup> <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/>

disrupt continuity of care, increase health care costs, and undermine quality improvement efforts. Removal of these outdated barriers should serve as a bedrock of Medicare reimbursement reform.

The purpose of the *ICAN Act* is to increase access, improve quality of care, and lower costs in the Medicare and Medicaid programs by removing federal barriers to practice for APRNs, *consistent with state law*. We urge Congress to pass this important legislation. It will move our health care system forward in an effective and efficient manner for the benefit of patients and providers. More than 240 organizations have endorsed this legislation, including the National Rural Health Association, AARP, the American Health Care Association, and Leading Age.

In closing, I would like to thank you for your leadership and for your willingness to consider our perspective on this critical issue to ensure that patients have access to qualified, high-quality providers. ANA stands ready to work with the Finance Committee to implement policy solutions to comprehensively address the nation's challenges addressing chronic care. If you have any questions, please contact Tim Nanof, Vice President of Policy and Government Affairs, at (301) 628-5081 or [Tim.Nanof@ana.org](mailto:Tim.Nanof@ana.org).

Sincerely,



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