March 12, 2015

The Honorable Joseph R. Pitts
Chairman, Energy and Commerce Health Subcommittee
2125 Rayburn House Office Building
Washington, D.C. 2515-6115

Dear Chairman Pitts,

As President of the American Association of Nurse Practitioners, the largest full service professional membership organization for nurse practitioners (NPs) representing the more than 205,000 nurse practitioners across the nation, I would like to thank you, Ranking Member Green and the Committee, for the opportunity to testify at the January 22, 2015 hearing *"A Permanent Solution to the SGR: The Time is Now."* Pursuant to the Committee's request for additional questions for the record, please find my response below as well as an attached copy of my testimony.

## The Honorable Eliot Engel

**I have been hearing from the physician community in New York for years about their growing frustration at the constant threat of significant reimbursement cuts. They frequently mention that the cost of running their practice is increasing each year and they are trying to properly treat patients with increasingly complicated medical conditions. All the while, facing double digit reimbursement cuts. It just isn't right.**

a. **Can you elaborate on why it is urgent for physicians and patient access to care that Congress reform the Medicare reimbursement system now and how another patch would be detrimental to our Medicare program?**

Answer:
Congress should move quickly to pass a permanent fix to the Medicare SGR. The uncertainty that comes with the yearly patch makes many providers, including nurse practitioners, concerned. We must continue to ensure access to care for our patients.

**The Honorable Doris O. Matsui**

1. **As I mentioned in my opening statement yesterday, this Committee worked hard with our colleagues on Ways & Means and Senate Finance to come up with a bipartisan, bicameral solution to the SGR problem last year. Following on goals set by the ACA, we need to continue to move away from fee-for-service and toward delivery system that rewards quality and value rather than volume. This means incentivizing care coordination across providers, the use of technology to communicate and track data, and management of chronic conditions in a quality-focused, patient-centered, team-based approach.**

    a. **The SGR repeal and replace policy provides incentives and a pathway for physicians to develop and participate in new models of healthcare delivery and payment, such as patient-centered medical homes. Please discuss the positive impact that increased participation in these models could have.**

Answer:
Nurse Practitioners strongly believe in patient centered care. In fact, one of the attributes that sets NPs apart from other health care providers is their unique emphasis on the health and well-being of the whole person. With a focus on health promotion, disease prevention, and health education and counselling, NPs guide patients in making smarter health and lifestyle choices, which in turn, provides patients with the tools they need to get healthy and stay healthy. Any new models that are developed should include input from Nurse Practitioners from the beginning. NPs can, and do lead medical homes, and as these types of discussions move forward, it is critical that all applicable health care providers are included in this process.

    b. **Please discuss the benefits to patients of better coordination of care.**

Answer:
Nurse Practitioners have been providing primary, acute and specialty healthcare to patients of all ages and walks of life for a half a century. NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans – including prescribing medications. NPs coordinate the care of their patients, whether it be managing referrals or working to ensure that treatment plans are created that allow the best patient compliance. Having one provider focused on coordination helps patients achieve healthy outcomes.

**The Honorable Ben Ray Lujan**

1. **The current Sustainable Growth Rate (SGR) Medicare payment system is unsustainable and needs to be fixed. In New Mexico, I continue to hear from providers and seniors about their frustration with SGR and the uncertainty that it creates. We cannot continue to patch this broken system, and we've been talking about a permanent fix for years. We need to deal with this now, and I support the bipartisan/bicameral SGR structural reform that was crafted last Congress that is supported by both provider and beneficiary groups.**

    a. **In New Mexico there is a shortage of primary care physicians. Can you speak to how delivery system reform is connected to SGR repeal? How do you see the move away from fee for service impacting doctors' participation in Medicare?**

Answer:
New Mexico is a state that has been actively recruiting nurse practitioners to practice in their state. They recognize the positive health care results of having nurse practitioners as primary care providers. A large majority of nurse practitioners, 76% of the 205,000 practicing NPs across the country, are primary care providers. As states take actions to allow full practice authority for nurse practitioners, access to care is less delayed, and patients will benefit. NPs practice in every state in accordance with state scope of practice laws. Currently, 20 states and the District of Columbia have granted full practice authority to NPs.

    b. **Given all we know about the impact of primary care on quality, patient satisfaction, and costs, what more do you believe we should do to promote and support our primary care physicians?**

Answer:
Investments in primary care are important but need to take into account all providers who are providing these services to patients, including nurse practitioners. NPs are the providers of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to NPs in 2012, a number we anticipate will continue to grow in the coming years. AANP strongly believes this serves as a testament to the trust that patients have in our workforce. NPs practice in every community in this country, both urban and rural, and provide care to patients from all economic and social backgrounds.

Sincerely,

Kenneth P. Miller, PhD, RN, CFNP, FAAN, FAANP
President

cc: Gene Green, Ranking Member Subcommittee on Health

# STATEMENT
## *Of*
## Kenneth P. Miller, PhD, RN, CFNP, FAAN, FAANP
## *To*
## United States House of Representatives
## Committee on Energy & Commerce
## Subcommittee on Health
## *On*
## "*A Permanent Solution to the SGR: The Time is Now*"

## January 22, 2015

Thank you Chairman Pitts, Ranking Member Green, and members of the Committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners (AANP), the largest full service professional membership organization for nurse practitioners (NPs) of all specialties. With over 56,000 individual members and over 200 organization members, we represent the more than 205,000 nurse practitioners across the nation.

My name is Kenneth Miller. I am the current President of AANP. I am a family nurse practitioner and previously served as Associate Dean for Academic Administration at The Catholic University of America in Washington, DC, the Director of the School of Nursing for the University of Delaware and the Vice Dean for Internal Programs and Associate Dean for Research and Clinical Scholarship in the College of Nursing at the University of New Mexico Health Sciences Center.

On behalf of the American Association of Nurse Practitioners, I am here to confirm our support of efforts to repeal the Medicare SGR, particularly the "SGR Repeal and Medicare Provider Payment

Modernization Act of 2014" (H.R. 4015) proposed in the last Congress. As you may know, nurse practitioners have been providing primary, acute, and specialty care for half a century, and are rapidly becoming the health care provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to NPs in 2012, a number we anticipate will continue to grow in the coming years. AANP strongly believes this serves as a testament to the trust that patients have in our workforce. NPs practice in every community in this country, both urban and rural, and provide care to patients from all economic and social backgrounds.

Our data shows that the vast majority of NPs in the United States are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers and over seventy- five percent currently practice in primary care settings. NPs bring a comprehensive perspective to health care by blending clinical expertise in diagnosing and treating acute and chronic illnesses with an added emphasis on health promotion and disease prevention. This comprehensive perspective is deeply rooted in nurse practitioner education. All NPs must complete a master's or doctoral program, and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings. Daily practice includes: assessment, ordering, performing, supervising and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment including prescribing medication (as well as non-pharmacologic treatments), coordination of care, counseling, educating patients, their families and communities.

NPs undergo rigorous national certification, periodic peer review, clinical outcome evaluations, and adhere to a strict code for ethical practice. Self-directed continued learning and professional

development is also essential to maintaining clinical competence. It is important to note that NPs are licensed in all states and the District of Columbia and practice under the rules and regulations of the state in which they are licensed. The following documents are enclosed for your reference: NP Facts, Scope of Practice for Nurse Practitioners, Standards of Practice for Nurse Practitioners, Quality of Nurse Practitioner Practice, and Nurse Practitioner Cost Effectiveness.

Nurse practitioners provide care in nearly every health care setting including clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics and homeless clinics. It is important to remember that in many of these settings nurse practitioners are the lead onsite provider. With nurse practitioners providing care in a wide variety of settings, they have continuously played a key role in treating Medicare beneficiaries. Nurse practitioners have received direct reimbursement for providing Medicare Part B services in all settings since 1998. Over 174,000 nurse practitioners, nearly eighty-five percent of the current NP workforce, are treating Medicare beneficiaries. Additionally, Medicare data shows that almost seventeen percent of beneficiaries in traditional fee-for-service coverage receive one or more services every year from NPs that bill Medicare directly. For many beneficiaries, especially rural and underserved populations, NPs are the only health care provider available.

Every day, increasing numbers of ‘baby boomers” become eligible for Medicare. Projections show that the number of beneficiaries are expected to increase by 20 million over the next 10 years resulting in approximately 72 million patients being treated. Nurse practitioners are ready to do their part to ensure these patients receive timely high quality care. According to the American Association of Colleges of

Nursing, there are currently 63,000 students enrolled in nurse practitioner programs in the United States with over 16,000 students graduating in 2014. Of those graduates, eighty-five percent were prepared in primary care. The evidence shows that nurse practitioners comprise a highly educated and sustainable workforce that daily provides comprehensive care to the Medicare population. Recently, U.S. News & World Report ranked nurse practitioners as number two on their top ten list of "Best Jobs of 2015". The U.S. Department of Labor's Bureau of Labor Statistics predicts that the NP occupation will see tremendous growth between 2012 and 2022. As the size of the Medicare system continues to grow, nurse practitioners will continue to be in a position to care for the beneficiaries in all settings throughout the country, not only because of the current workforce, but because of their strong educational pipeline.

Today, the American Association of Nurse Practitioners reaffirms its support of the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015) proposed in the last Congress which would permanently repeal the flawed "sustainable growth rate" (SGR) formula for Medicare Part B and further reform the Medicare Payment System. We commend the Committee for their bipartisan legislative proposal which recognizes all Part B providers, including nurse practitioners. Throughout the development of this legislation, the Committee gave all stakeholders the opportunity to provide comments. This open process lead to a strong bipartisan product, and this process should serve as a model as we move forward. The overall focus of the legislation seeks to include all Medicare Part B providers by utilizing provider neutral language. In addition, it includes a number of proposals that reflect the full partnership of nurse practitioners in the Medicare Program; specifically, the inclusion of nurse practitioners in the first year of the Merit-based Incentive Payment System (MIPS), and ensuring

that nurse practitioner led Patient Centered Medical Homes (PCMH) are eligible to receive incentive payments for the management of patients with chronic disease.

Additionally, it is our belief that repealing and replacing the current SGR formula will benefit both beneficiaries and providers in the Medicare system. Replacing the SGR methodology with a stable system of payments that fairly compensates all health care professionals will help to ensure the unobstructed delivery of the high quality, cost efficient services that Medicare beneficiaries need.
As Congress moves forward to address the current Medicare payment system, the American Association of Nurse Practitioners would like to reiterate its support for the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015) proposed in the last Congress. AANP is ready to provide support throughout the legislative process in the 114th Congress and looks forward to working with the Committee and this Congress on the passage of this bill in 2015. In the interest of the patients for whom we provide care, we strongly urge Congress to move to enact this legislation.

The American Association of Nurse Practitioners thanks the Committee for their work on this important issue, and we look forward to working together to repeal the Medicare SGR and reform Medicare Part B reimbursement policy to ensure patients have access to the health care they need. We thank you for your time, and we are pleased to continue to work together on this important issue in the days ahead.

Attachments:
1. AANP NP Facts
2. AANP Scope of Practice for Nurse Practitioners
3. AANP Standards of Practice for Nurse Practitioners
4. AANP Quality of Nurse Practitioner Practice
5. AANP Cost Effectiveness
6. APRN Workgroup H.R. 4015 support letter

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# NP Facts

*The Voice of the Nurse Practitioner®*

**There are more than 205,000 nurse practitioners (NPs) practicing in the U.S.**

- An estimated 15,000 new NPs completed their academic programs in 2012-2013
- 95.1% of NPs have graduate degrees
- 96.8% of NPs maintain national certification
- 87.2% of NPs are prepared in primary care; 75.6% of NPs practice in at least one primary care site
- 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid
- 44.8% of NPs hold hospital privileges; 15.2% have long term care privileges
- 97.2% of NPs prescribe medications, averaging 19 prescriptions per day
- NPs hold prescriptive privilege in all 50 states and D.C., with controlled substances in 49
- The early-2011 mean, full-time NP base salary was $91,310, with average full-time NP total income $98,760
- The majority (69.5%) of NPs see three or more patients per hour
- Malpractice rates remain low; only 2% have been named as primary defendant in a malpractice case
- Nurse practitioners have been in practice an average of 11.7 years

***Distribution, Mean Years of Practice, Mean Age by Population Focus***

| Population | Percent of NPs | Years of Practice | Age |
|---|---|---|---|
| Acute Care | 6.3 | 7.7 | 46 |
| Adult+ | 18.9 | 11.6 | 50 |
| Family+ | 48.9 | 12.8 | 49 |
| Gerontological+ | 3.0 | 11.6 | 53 |
| Neonatal | 2.1 | 12.2 | 49 |
| Oncology | 1.0 | 7.7 | 48 |
| Pediatric+ | 8.3 | 12.4 | 49 |
| Psych/Mental Health | 3.2 | 9.1 | 54 |
| Women's Health+ | 8.1 | 15.5 | 53 |

*+Primary care focus*

Sources:
AANP National NP Database, 2014
Fang, D., Li, Y., Bednash, G.D. (2014) 2012-2013 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing.* Washington DC: AACN
2012 AANP Sample Survey
2010 AANP National Practice Site Survey
2011 AANP National NP Compensation Survey

**Additional information is available at the AANP website www.aanp.org.**

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# *Scope of Practice for Nurse Practitioners*

## Professional Role

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families and groups accordant with their practice specialties. In addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. Services include ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, prescribing pharmacological agents and non-pharmacologic therapies, and teaching and counseling patients, among others.

As licensed, independent clinicians, NPs practice autonomously and in collaboration with health care professionals and other individuals. They serve as health care researchers, interdisciplinary consultants and patient advocates.

## Education

NPs are advanced practice nurses - health care professionals who have achieved licensure and credentialing well beyond their roles as registered nurses (RNs). All NPs obtain graduate degrees and many go on to earn additional post-master's certificates and doctoral degrees. Didactic and clinical courses provide NPs with specialized knowledge and clinical competency which enable them to practice in primary care, acute care and long-term care settings. Self-directed continued learning and professional development are hallmarks of NP education.

## Accountability

The autonomous nature of NP practice requires accountability for health care outcomes and thus national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continued professional development and maintenance of clinical skills. NPs are committed to seeking and sharing information that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research and applying findings to clinical practice.

## Responsibility

The role of the NP continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, NPs combine the roles of providers, mentors, educator, researchers and administrators. They also take responsibility for advancing the work of NPs through involvement in professional organizations and participation in health policy activities at the local, state, national and international levels.



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# *Standards of Practice for Nurse Practitioners*

## I. Qualifications

Nurse practitioners are licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice (AANP 2006).

## II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

A. Assessment of health status

The nurse practitioner assesses health status by:

- Obtaining a relevant health and medical history
- Performing a physical examination based on age and history
- Performing or ordering preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process
- Synthesizing and analyzing the collected data
- Formulating a differential diagnosis based on the history, physical examination and diagnostic test results
- Establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests
- Prescribing or ordering appropriate pharmacologic and non-pharmacologic interventions
- Developing a patient education plan
- Recommending consultations or referrals as appropriate

D. Implementation of the plan

Interventions are based upon established priorities. Actions by the nurse practitioners are:

- Individualized
- Consistent with the appropriate plan for care
- Based on scientific principles, theoretical knowledge and clinical expertise
- Consistent with teaching and learning opportunities

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

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## III. Care Priorities

The nurse practitioner's practice model emphasizes:

A. Patient and family education
   The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family

B. Facilitation of patient participation in self care.
   The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:
   - Promotion, maintenance and restoration of health
   - Consultation with other appropriate health care personnel
   - Appropriate utilization of health care resources

C. Promotion of optimal health

D. Provision of continually competent care

E. Facilitation of entry into the health care system

F. The promotion of a safe environment

## IV. Interdisciplinary and Collaborative Responsibilities

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

## V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible and confidential records.

## VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

## VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

A. Participation in quality assurance review, including the systematic, periodic review of records and treatment plans
B. Maintenance of current knowledge by attending continuing education programs
C. Maintenance of certification in compliance with current state law
D. Application of standardized care guidelines in clinical practice

## VIII. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families and other professionals.

## IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

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# Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965 and over 45 years of research consistently supports the excellent outcomes and high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

**Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. Archives of Internal Medicine, 151(4), 694-698.**
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

**Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. Research in Gerontological Nursing, 1(3), 177-185.**
Bakerjian conducted and extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

**Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44(6), 332-9.**
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

**Congressional Budget Office. (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.**
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

**Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. Journal of Advanced Nursing, 40(6), 771-730.**
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

**Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. Medical Decision Making, 26, 9-17.**
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

**Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. British Medical Journal, 324, 819-823.**
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative

comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

**Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. Cochrane Database of Systematic Reviews. 2006, Issue 1.**
This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

**Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. Medical Care Research and Review 61(3), 332-351.**
The outcomes of care in the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

**Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. Nursing Economics, 20(4), 174-179.**
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast , PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

**Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. Journal of the American Medical Association, 283(1), 59-68.**
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

**Newhouse, R. et al (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. Nursing Economic$, 29 (5), 1-22.**
The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction, patient perceived health status, functional status, hospitalizations, ED visits, and bio-markers such as blood glucose, serum lipids, blood pressure. The authors conclude that NP patient outcomes are comparable to those of physicians.

**Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.**
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have." (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

**Ohman-Strickland, P.A., Orzano, A.J., Hudson, S.V., Solberg, L.I., DiCiccio-Bloom, B., O'Malley, D., et al. (2008). Quality of diabetes care in family medicine practices: Influence of nurse-practitioners and physician's assistants. Annals of Family Medicine, 6(1), 14-22.**
The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lips, and microalbumin levels and were more likely to be at target for lipid levels.

**Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. Nurse Practitioner, 1(1), 28-32.**
The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

**Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? Medical Care, 42(6), 606-623.**
A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

**Sacket, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. Annals of Internal Medicine, 80(2), 137-142.**
A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

**Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9(2).**
The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

**Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hacket, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine, 290 (3), 252-256.**
This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

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# *Nurse Practitioner Cost-Effectiveness*

Nurse Practitioners (NPs) are a proven response to the evolving trend towards wellness and preventive health care driven by consumer demand. A solid body of evidence demonstrates that NPs have consistently proven to be cost-effective providers of high-quality care for almost 50 years. Examples of the NP cost-effectiveness research are described below.

Over three decades ago, the Office of Technology Assessment (OTA) (1981) conducted an extensive case analysis of NP practice, reporting that NPs provided equivalent or improved medical care at a lower total cost than physicians. NPs in a physician practice potentially decreased the cost of patient visits by as much as one third, particularly when seeing patients in an independent, rather than complementary, manner. A subsequent OTA analysis (1986) confirmed original findings regarding NP cost effectiveness. All later studies of NP care have found similar cost-efficiencies associated with NP practice.

The cost-effectiveness of NPs begins with their academic preparation. The American Association of Colleges of Nursing has long reported that NP preparation cost 20-25% that of physicians. In 2009, the total tuition cost for NP preparation was less than one-year tuition for medical (MD or DO) preparation (AANP, 2010).

Comparable savings are associated with NP compensation. In 1981, the hourly cost of an NP was one-third to one-half that of a physician (OTA). The difference in compensation has remained unchanged for 30 years. In 2010, when the median total compensation for primary care physicians ranged from $208,658 (family) to $219,500 (internal medicine) (American Medical Group Association, 2010), the mean full-time NP's total salary was $97,345, across all types of practice (American Academy of Nurse Practitioners [AANP], 2010). A study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs and total labor costs per visit were both lower in practices where NPs and physician assistants (PAs) were used to a greater extent (Roblin, Howard, Becker, Adams, and Roberts, 2004). When productivity measures, salaries, and costs of education are considered, NPs are cost effective providers of health services.

Based on a systematic review of 37 studies, Newhouse et al (2011) found consistent evidence that cost-related outcomes such as length of stay, emergency visits, and hospitalizations for NP care are equivalent to those of physicians. In 2012, modeling techniques were used to predict the potential for increased NP cost-effectiveness into the future, based on prior research and data. Using Texas as the model State, Perryman (2012) analyzed the potential economic impact that would be associated with greater use of NPs and other advanced practice nurses, projecting over $16 billion in immediate savings which would increase over time.

NP cost-effectiveness is not dependent on actual practice setting and is demonstrated in primary care, acute care, and long term care settings. For instance, NPs practicing in Tennessee's state-managed managed care organization (MCO) delivered health care at 23% below the average cost associated with other primary care providers, achieving a 21% reduction in hospital inpatient rates and 24% lower lab utilization rates compared to physicians (Spitzer, 1997). A one-year study comparing a family practice physician-managed practice with an

NP-managed practice within an MCO found that compared to the physician practice, the NP-managed practice had 43% of the total emergency department visits, 38% of the inpatient days, and 50% total annualized per member monthly cost (Jenkins and Torrisi, 1995). Nurse managed centers (NMCs) with NP-provided care have demonstrated significant savings, less costly interventions, and fewer emergency visits and hospitalizations (Hunter, Ventura, and Kearns, 1999; Coddington and Sands, 2009). A study conducted in a large HMO setting established that adding an NP to the practice could virtually double the typical panel of patients seen by a physician with a projected increase in revenue of $1.28 per member per month, or approximately $1.65 million per 100,000 enrollees annually (Burl, Bonner, and Rao, 1994).

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Chenowith, Martin, Pankowski, and Raymond (2005) analyzed the health care costs associated with an innovative on-site NP practice for over 4000 employees and their dependents, finding savings of $ .8 to 1.5 million, with a benefit-to-cost ratio of up to 15 to 1. Later, they tested two additional benefit-to-cost models using 2004-2006 data for patients receiving occupational health care from an NP demonstrating a benefit to cost ratio ranging from 2.0-8.7 to 1, depending on the method (Chenowith, Martin, Pankowski, and Raymond (2008). Time lost from work was lower for workers managed by NPs, compared to physicians, as another aspect of cost-savings (Sears, Wickizer, Franklin, Cheadie, and Berkowitz, 2007).

A number of studies have documented the cost-effectiveness of NPs in managing the health of older adults. Hummel and Prizada (1994) found that compared to the cost of physician-only teams, the cost of a physician-NP team long term care facility were 42% lower for the intermediate and skilled care residents and 26% lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stay, and fewer specialty visits. A one-year retrospective study of 1077 HMO enrollees residing in 45 long term care settings demonstrated a $72 monthly gain per resident, compared with a $197 monthly loss for residents seen by physicians alone (Burl, Bonner, Rao, and Kan, 1998). Intrator (2004) found that residents in nursing homes with NPs were less likely to develop ambulatory care-sensitive diagnoses requiring hospitalizations. Bakerjian (2008) summarized a review of 17 studies comparing nursing home residents who are patients of NPs to others, finding lower rates of hospitalization and overall costs for the NP patients. The potential for NPs to control costs associated with the healthcare of older adults was recognized by United Health (2009), which recommended that providing NPs to manage nursing home patients could result in $166 billion healthcare savings.

NP-managed care within acute-care settings is also associated with lower costs. Chen, McNeese-Smith, Cowan, Upenieks, and Afifi (2009) found that NP-led care was associated with lower overall drug costs for inpatients. When Paez and Allen (2006) compared NP and physician management of hypercholesterolemia following revascularization, they found patients in the NP-managed group had lower drug costs, while being more likely to achieve their goals and comply with prescribed regimen.

Collaborative NP/physician management was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al., 2006; Ettner et al., 2006). The introduction of an NP model in a health system's neuroscience area resulted in over $2.4 million savings the first year and a return on investment of 1600 percent; similar savings and outcomes were demonstrated as the NP model was expanded in the system (Larkin, 2003). Boling (2009) cites an intensive short-term transitional care NP program documented by Smigleski et al through which healthcare costs were decreased by 65% or more after enrollment, as well as the introduction of an NP model in a system's cardiovascular area associated with a decrease in mortality from 3.7% to 0.6% and over 9% decreased cost per case (from $27,037 to $24,511).

In addition to absolute cost, other factors are important to health care cost-effectiveness. These include illness prevention, health promotion, and outcomes. See Documentation of Quality of Nurse Practitioner Practice (AANP, 2013) for further discussion.

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January 20, 2015

Hon. Joe Pitts, Chairman
House Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Hon. Gene Green, Ranking Member
House Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
2415 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

In anticipation of your January 21-22 hearings titled, "A Permanent Solution to the SGR: The Time is Now," we write as organizations representing roughly 340,000 Advanced Practice Registered Nurses (APRNs) in the United States in support of permanent SGR repeal and the Medicare reforms included in HR 4015 considered by the 113th Congress. Repealing the Medicare sustainable growth rate (SGR) and reforming Medicare Part B payment are long overdue. In the interest of the patients for whom we provide care, we strongly support Congress moving to enact legislation providing permanent SGR repeal and Medicare payment reforms. Payment reforms should recognize APRNs the same as physicians in reimbursement and in the development and implementation of quality measures for payment incentives when the same quality services are provided.

Our 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. Totaling roughly 340,000 healthcare professionals, including two of the ten largest categories of Medicare Part B provider specialties according to Medicare claims data, 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.

APRNs provide crucial care to patients in every environment that healthcare is delivered, contribute to community health and healthcare delivery for populations, and engage in leadership activities necessary to promote patient access to better healthcare and cost savings. The care that our members provide includes services billed directly to Part B, services bundled into hospital or other facility claims, services billed "incident-to" the services of a physician and reported by the physician not the APRN providing the care, and population and community healthcare. **Thus, as Congress works on legislation to repeal the SGR and reform the Medicare payment system, we ask on behalf of the patients for whom we provide care that you keep this in mind: Nurses will always put patients first.**

**APRNs Support Repealing the SGR and Reforming Medicare Payment**

Because Medicare covers APRN services under Part B, we join in expressing support for repeal of Medicare SGR cuts that frequently threaten Medicare beneficiaries, providers and the Medicare program with unsustainable and draconian cuts. Over the next 10 years the Medicare population will increase by 20 million beneficiaries to 72 million. We look forward to continuing work with you to enact legislation that stabilizes Medicare payment and promotes innovations that increase quality and access and help control healthcare cost growth, and to addressing the issues associated with its costs.

In *The Future of Nursing: Leading Change, Advancing Health* report, the Institute of Medicine's (IOM) first recommendation is for APRNs to practice to the fullest scope of their education and training, and its third is to expand opportunities for RNs and APRNs to develop and exercise leadership in redesigning healthcare in the United States. The IOM recommends policymakers eliminate barriers to the fullest and best use of APRNs, not only so that they can practice to the fullest extent of their license but also to provide for the growing number of Medicare beneficiaries and other patients' access to high quality, cost-effective care. This action is a crucial imperative at every level of healthcare policy from Congress and the Administration, to states, to healthcare facilities and private enterprise, and in every part of our country, particularly rural and medically underserved America which rely heavily on APRN care. Failure to make the highest and best use of APRNs by protecting unnecessary and costly guild-driven barriers to their care denies patient access to quality care, limits healthcare improvement, and wastes taxpayer and private resources.

We hope that the legislative process would support fair consideration and funding of a positive update for fee for service providers. We also request that further consideration of offsetting revenue sources for this legislative package promote sound healthcare policy. We support improvements to the 113th Congress legislation that promote patient access to safe, cost-effective healthcare by recognizing APRNs so that they may practice at their full scope and exercise leadership in healthcare transformation – recommendations consistent with the IOM report. Furthermore, we would request lawmakers oppose any amendments that would impair patient access to APRNs practicing to their full scope, and any anesthesia policy related amendments that do not have the support of national organizations representing CRNAs and anesthesiologists.

Thank you for your consideration, and we look forward to continuing to engage with you in support of legislation permanently repealing the cycle of SGR cuts that harm healthcare and reforming Medicare payment to promote access to quality care. If you have any questions, please contact Frank Purcell at the AANA Washington office, 202-484-8400, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American Association of Nurse Practitioners

American College of Nurse-Midwives

American Nurses Association
Gerontological Advanced Practice Nurses Association
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Organization of Nurse Practitioner Faculties