

Medicare Payment for Registered Nurse Services and Care Coordination

This paper summarizes how Medicare pays for the services of nurses under its various payment systems, reviews Medicare payment for patient care coordination and how these care coordination programs might compensate nursing services, and addresses various proposals to provide better access to or more favorable payment for nursing services that could be adopted either legislatively or through regulation.

I. How Does Medicare Decide What Services to Pay For?

Medicare is a defined benefit category program. Medicare can pay for any service that is described by a benefit category in Title XVIII of the Social Security Act. Advanced Practice Registered Nurses (APRN) with distinct Medicare benefit categories include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse-midwives (CNMs). Under current law Medicare cannot make direct payments to registered nurses under Part B.

Other nursing services will usually be encompassed by a more broadly described benefit category that allows Medicare to compensate the nurse's employer. For instance, Medicare will pay physicians, hospitals, skilled nursing facilities, home health agencies, and others for the services of nurses that are either directly employed or under contract through benefit categories that allow each of these institutional or practitioner types to be paid by Medicare.

Medicare pays for therapeutic services provided by registered nurses in physician offices and hospital outpatient departments under the "incident to" a physician's service benefit category. Medicare's payment will be made to the nurse's employer—a hospital or a physician. "Incident to" a physician service means that the patient has or will be seeing the physician or APRN and the related service being provided by the nurse or other staff is "incident to" the physician service. Medicare may also pay for nursing services and other staff employed by physicians and hospitals through the "laboratory tests, X-ray tests and other tests" benefit category.

"Incident to" services are generally required to be under the direct supervision of a physician or nonphysician practitioner such as an APRN as a condition of payment. Nursing services provided under the diagnostic tests benefit category may require general, direct, or personal supervision. "Direct supervision" means that the physician or other practitioner must be immediately available (although not in the room or within any physical boundary of the property) to furnish assistance and direction throughout the performance of the procedure. "General supervision" means the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the procedure. "Personal" supervision means a physician must be in attendance in the room during the procedure.

I. How Does Medicare Decide How to Pay for Services in the Different Benefit Categories?

The first step in deciding whether Medicare can pay for an item or service is determining whether the service has a benefit category. The second step is deciding whether the service is “reasonable and necessary for treatment of illness or injury.” Once it is determined that an item or service has a benefit category and that the service is reasonable and necessary, the last step before making payment is deciding how the service is to be paid.

Each benefit category is associated with a particular payment mechanism:

- **Inpatient Hospital Prospective Payment System (IPPS):** Used to pay for all services provided from inpatient admission to discharge and preadmission services provided by the hospital. Fixed per-discharge payment to the hospital includes compensation for employed or contracted staff including nurses.
- **Outpatient Prospective Payment System (OPPS):** Hybrid of a fee schedule and a prospective payment system used to pay hospitals for outpatient diagnostic and therapeutic services, including the services of employed or contracted staff such as nurses.
- **Skilled Nursing Facility (SNF) Prospective Payment System (PPS):** Used to pay for post-hospital extended care services. Per diem payment to the SNF includes compensation for employed or contracted staff such as nurses.
- **Home Health Agency (HHA) PPS:** Used to pay for post-hospital services in a patient’s home. Sixty-day per-episode payment to the HHA includes payment for employed or contracted staff such as nurses.
- **Physician Fee Schedule (PFS):** Used to pay for physician and other practitioner services in any site of service. APRN services are paid using the PFS, as are “incident to” and diagnostic services furnished in a physician’s or practitioner’s office. The Act requires NPs and CNSs to be paid 85% of the amount paid to a physician. CNMs have been paid at 100% of the physician rate beginning January 1, 2011. CRNAs are paid 100% of the PFS or a special anesthesia fee schedule when furnishing services on their own. Payment may be made to an employer when the CRNA is furnishing anesthesia under the medical direction of an anesthesiologist.

II. Medicare Care Coordination Initiatives

The Centers for Medicare and Medicaid Services (CMS) has a number of care coordination initiatives currently underway that are part of the current Medicare fee-for-service program and models or experiments in which the Center for Medicare and Medicaid Innovation (CMMI) has authority under section 3021 of the Affordable Care Act to waive current provisions of law and regulations.

Care coordination initiatives under the current fee service program include:

- **Transitional Care Management (TCM):** TCM covers services provided to a Medicare beneficiary in the 30 days following a discharge from a hospital or SNF to assist in the beneficiary’s transition to the community setting. Nurses employed or under contract to a practitioner providing TCM may provide the care coordination portion of TCM under general supervision.
- **Chronic Care Management (CCM):** CCM consists of care management services for patients with two or more chronic conditions and who meet other criteria. Allowing nurses to provide these care management services under general supervision allows clinical staff coordination activities to be furnished remotely from where the physician or APRN is practicing.
- **Psychiatric Collaborative Care Model (CoCM):** Psychiatric CoCM typically is provided by a primary care team consisting of a primary care practitioner and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Like CCM, general supervision provides opportunities for

physicians and APRNs to contract for nursing care coordination services that may be provided remotely from the physician or APRN.

- **General Behavioral Health Integration (BHI):** General BHI describes care management services for patients with psychiatric conditions where the specific elements of the CoCM model may not be met. Clinical staff may provide the services under the general supervision of the billing practitioner.
- **Assessment and Care Planning for Patients with Cognitive Impairment:** While this service is designed to recognize the work of the physician or APRN, Medicare will provide compensation for nurses working under the direct supervision of a physician or APRN providing supportive care coordination services.
- **Accountable Care Organizations (ACO):** ACOs are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to provide coordinated high-quality care to their Medicare patients. As in other care coordination initiatives under way in Medicare, there may be a role for nurses in care coordination and management to the extent that an ACO sets up an explicit care management infrastructure.

Care coordination models under study by CMMI:

- **Comprehensive Primary Care (CPC)+:** CPC+ is a multipayer 5-year model designed to build capabilities and processes to deliver better care through a risk-adjusted, prospective, monthly care management fee and performance-based incentive payments. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination. This model provides opportunities for NPs and CNSs to be directly eligible for care coordination payments under CPC+.
- **Oncology Care Model (OCM):** OCM practices receive \$160 per beneficiary per month for a 6-month episode of chemotherapy treatment and provides the opportunity for performance-based incentives based on lowering the total cost of care and improving quality. The \$160 per beneficiary per month fee can be used to support care coordination activities that are not subject to Medicare's supervision rules.
- **Bundled Payment for Care Initiative (BPCI):** BPCI comprises four broadly defined models of care that link payments for multiple services beneficiaries receive during an episode of care. Organizations enter into payment arrangements that include financial and performance accountability for episodes of care. BPCI is focused on episode-based care coordination among hospitals, physicians, and postacute care providers, depending on the model. To the extent that there are opportunities for nurses to be involved in care coordination, it would be through the risk-bearing entity.
- **Comprehensive Care for Joint Replacement (CJR) and Episode Payment Models (EPM):** CJR began April 1, 2016, and will run for approximately 5 years. Controversially, CJR mandated participation in 67 metropolitan statistical areas. CMS recently proposed to make CJR mandatory in 34 areas and optional in 33 areas where it is already underway. Like BPCI, CJR has no specific payment for care coordination but the hospital is given incentives to work with physicians, practitioners, postacute care providers, and others involved in patient treatment and recovery for LEJR. CJR waives requirements for nurses and other licensed clinical personnel to work under the direct supervision of a physician or an APRN when providing postdischarge visits in the patient's home or place of residence any time during the episode.

In 2016, CMS completed final regulations to adopt new EPM models for Acute Myocardial Infarction, Coronary Artery Bypass Graft, Surgical Hip and Femur Fracture. As part of this same regulation, CMS adopted the Cardiac Rehabilitation Incentive Payment Model. EPMs were designed to work similarly to CJR. However, CMS recently proposed to cancel EPMs and the Cardiac Rehabilitation Incentive Payment Model.

III. Statutory or Regulatory Changes to Facilitate Access to Nursing Services

Make Payment to NPs and CNSs at the Same Rate as Physicians: The Medicare statute requires NPs and CNSs to be paid 85% of what Medicare would pay a physician for the same service. Until January 1, 2011, CNMs were paid 65% of the MPFS payment amount. Beginning January 1, 2011, Medicare began paying CNMs 100% of the MPFS amount. The same payment limitations have never applied to CRNAs. The statute resulted in Medicare paying less to NPs and CNSs than to CRNAs and CNMs for the same services. It does not appear logical to pay APRNs differently for the same service depending upon whether the APRN is an NP, CNS, CRNA, or CNM. Irrespective of the logic of the payment limitation for NPs and CNSs, Congress has been resistant to statutory change to eliminate the payment limitation.

Consistent Definition of the Term “Physician”: In some contexts, CMS views the term “physician” as being limited to MDs and DOs, while in other contexts CMS has used a more expansive definition of “physician” to include nonphysician practitioners. CMS allows NPs and CNSs to supervise “incident to” services but not diagnostic tests or cardiac and intensive cardiac rehabilitation services. The ostensible reason is that section 1861(r) of the Social Security Act defines the term “physician” to mean MD and DO. However, CMS uses the same statutory term differently depending on the context.

Change the Statute to Allow Direct Payment to Registered Nurses (RNs): For Medicare to make direct payment to RNs for care coordination activities, Congress would have to change the statute to explicitly add a benefit category for RNs. Achieving a statutory change to allow direct payment to RNs will be challenging because other practitioners would likely want the same treatment and it would be costly for Congress to make such a change. Nevertheless, there are models that RNs could mimic (specifically Medical Nutrition Therapy) in an effort to achieve this goal. Nurses could also seek to undertake a model under CMMI’s waiver authority to study whether direct payment to RNs can achieve Medicare cost savings and quality improvement goals.