American Association
of Colleges of Nursing

September 4, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma,

The American Association of Colleges of Nursing (AACN) offers the following comments in response to the Centers for Medicare and Medicaid Services' (CMS) proposed *Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020*, file code CMS-1715-P.

As the national voice for baccalaureate and graduate nursing education, AACN has a vested interest in improving health and health care throughout the nation. For more than five decades, AACN has established quality standards for professional nursing education to ensure that Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs; which include Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs)) are prepared to provide evidence-based and cost-effective care. Within AACN member schools, more than 100,000 nursing students are currently enrolled in APRN programs and will serve as our nation's next generation of expert providers.[1]

AACN supports CMS initiatives that aim to reduce unnecessary regulatory burdens and eliminate wasteful Medicare expenditures, while increasing patients' access to affordable, high-quality care. We appreciate the opportunity to provide comment on proposed rules that specifically eliminate regulations currently harming health care delivery by impeding the scope of practice of highly qualified clinicians.

AACN applauds the proposed rule on medical record documentation under Payment for Evaluation and Management (E/M) Visits which relieves burdensome E/M documentation requirements for NPs, CNSs, and CNMs who are authorized providers under Medicare Part B. Enabling the physician, the physician assistant (PA), or the APRN who furnishes and bills

[1] *2018-2019 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC: American Association of Colleges of Nursing.

for their professional services to **review and verify, rather than redocument**, information included in the medical record by physicians, residents, nurses, students or other members of the medical team reduces burden and eliminates disparities in clinical training opportunities.

AACN is pleased to see recognition of CRNA's to perform preanesthetic evaluation which increases efficiency. Specifically, the revisions proposed for Ambulatory Surgical Centers (ASCs) that enable CRNAs to perform the anesthetic risk and evaluation on the patients they are anesthetizing. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA and should be recognized in the same manner that Medicare recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. The change in regulation will help to increase efficiency and eliminate operational waste and delays in care in ASCs across the nation.

This proposed rule is forward-thinking and reflective of the professional health care setting by including APRN and PA preceptors and broadly interpreting "students" to include all members of the medical team with interprofessional education and training. Recognizing APRN and PA preceptors in the same manner as teaching physicians regarding student medical record documentation will not only reduce clinician burden, but it will advance access to quality care for Medicare beneficiaries by granting invaluable clinical training opportunities to APRN and PA students.

AACN offers the following recommendations to improve upon proposed changes in the 2020 Medicare Physician Fee Schedule:

- Include CRNAs among list of providers in revision to medical record documentation;
- Clarify that Changes to Ambulance Physician Certification Statement Requirement apply to emergency and non-emergency cases;
- Remove the administrative burden requiring physicians to provide face-to-face documentation for Home Health services;
- Adopt provider-neutral language in all regulatory interpretations of the law where appropriate;
- Amend statutory language to ensure that health-related federal committees and boards reflect diverse representation of the health workforce; and
- Correct provider attestation to accurately document services billed and remove "incident to" billing.

Recommendation: Include CRNAs Among List of Providers in Medical Record Documentation

AACN offers revisions regarding the definition of APRNs in E/M documentation. The proposed change currently only includes three out of the four APRNs: NPs, CNSs, and CNMs; but the proposed rule omits CRNAs. Taking into account that the CY 2013 Physician Fee Schedule final rule and Section 140.4.3 of the Medicare Claims Processing Manual language state that Medicare covers all medically necessary services provided by CRNAs within their state scope of practice, and noting that the current proposed rule, which enables APRNs to review and verify, rather than redocument, medical record information, would apply across the spectrum of all Medicare-covered services paid under the Physician Fee Schedule, AACN recommends that CMS include CRNAs in the list of providers. As CRNAs

regularly complete comprehensive E/M documentation for patients, this is well within their scope of practice.

Recommendation: Clarify that Changes to the Ambulance Physician Certification Statement Requirement Include Emergency and Non-emergency Cases

AACN supports CMS as it continues to identify and change unnecessary and burdensome regulations impacting health care providers and suppliers. The proposed rule under Changes to the Ambulance Physician Certification Statement (PCS) Requirement adds licensed practical nurses, social workers, and case managers to the list of non-physician staff who are authorized to sign a certification statement when the ambulance provider or supplier is unable to obtain a signed PCS from the attending physician.

AACN agrees with the expanded list of staff members able to sign a non-physician certification statement and recommends adding to the revision that licensed non-physician staff should be authorized to sign a certification statement for all emergency and non-emergency cases. Adding an additional layer of bureaucracy does not increase quality, but does increase cost.

Recommendation: Remove Barriers for NPs in Home Health Care

CMS should remove the outdated and unnecessary requirement that NPs must locate a physician to document that a face-to-face patient assessment for home health services has occurred and certify or recertify the home health plan of care. NPs are primary care providers in the Home Health Care Program, and yet, they are unable to initiate or make necessary modifications to medication or treatment without obtaining a physician's signature. This causes a delay in treatment and puts patients at risk for avoidable complications. Delays in care are entirely problematic for home health care patients who suffer from more chronic conditions and report more limitations on activities of daily living.[2] Moreover, the redundant structure where multiple providers are billing for repetitive services increases costs for taxpayers and patients.

It is important to note that the majority of the 86.6 percent of NPs certified in primary care see Medicare and Medicaid patients.[3] NPs complete more than one billion patient visits annually. The current barrier facing NPs in home health care is especially significant in light of the President's recent release of Executive Order 13879, Advancing American Kidney Health. It does not benefit the American people for CMS to limit allied health professionals' ability to care for a chronically ill population, given that, according to the Administration, "*37 million patients suffer from chronic kidney disease and more than 726,000 have end-stage renal disease."* Removing the administrative burden of requiring physician face-to-face documentation for home health services would ensure continuity of care and help achieve the goals sought under this Executive Order.

Recommendation: Adopt Provider-Neutral Language

AACN requests use of provider-neutral language in all regulatory rulemaking where appropriate. The December 2018 HHS report "Reforming America's Healthcare System through Choice and Competition" and the Medicare Access and CHIP Reauthorization Act

[2] Avalere Health. (September 2018). Home Health Chartbook 2018: Prepared for the Alliance for Home Health Quality and Innovation. Retrieved from http://ahhqi.org/images/uploads/AHHQI_2018_Chartbook_09.21.2018.pdf

[3] Centers for Medicare & Medicaid Services. Medicare Providers: Number of Medicare Non-Institutional Providers by Specialty, Calendar Years 2012-2016. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/Downloads/PROVIDERS/2016_CPS_MDCR_PROVIDERS_6.pdf

(MACRA) (H.R. 2, Pub. L. 114-10) both defined the Merit-based Incentive Payment System (MIPS)-eligible professionals to include physicians, PAs, NPs, CNSs, and CRNAs.[4,5] According to the March 2019 Medicare Payment Advisory Commission (MedPAC) report, which utilizes and highlights Fee for Service (FFS) claims data for years 2015 to 2017, the number of primary care physicians billing Medicare grew by one percent. Comparatively, the number of APRNs and PAs billing Medicare grew by 10 percent.[6]

Health care professionals representing disciplines beyond medicine continue to be on the frontlines, not only providing, but increasing access to high-quality care for the Medicare population. Where appropriate, CMS should update all regulatory language to reflect the full spectrum of health care providers delivering high-quality care to their communities.

Recommendation: Ensure Equal Representation on Federal Committees
The Federal Advisory Committee Act (FACA) mandates that Federal advisory committees be balanced in the points of view represented by the members. According to the General Services Administration (41 CFR § 102- 3.60(b)(3)), FACA requires (1) "that, in the selection of members for the advisory committee, the agency will consider a cross-section of those directly affected, interested, and qualified, as appropriate to the nature and functions of the advisory committee;" and (2) "[a]dvisory committees requiring technical expertise should include persons with demonstrated professional or personal qualifications and experience relevant to the functions and tasks to be performed."

In recognition of this mandate, AACN strongly recommends CMS support amendment of the statutory language in the FACA Membership Balance Plan holding each health-related federal committee responsible for ensuring that appointed members proportionately reflect the diverse representation of the health workforce. Nursing is the nation's largest health care profession, with more than 3.8 million RNs nationwide.[7] And yet, we note that physicians account for over half of the membership across many health-related federal advisory committees, task forces, and boards.

For example, the President's Council on Sports, Fitness, and Nutrition, formed to promote healthy lifestyles, does not include a nutritionist, dietician, or nurse professional, and yet, three physicians are current members. The U.S. Preventive Services Task Force, appointed by the Agency for Healthcare Research and Quality and consisting of a panel of national experts in prevention and evidence-based medicine, is currently comprised of 81% physicians and just one nurse. A third example is the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was chartered to assess physician-focused payment models—in which other health practitioners, including APRNs and other eligible clinicians, play a core role in implementing—has a current membership roster of 82% physicians, no nurses, and no other eligible clinicians.

[4] U.S. Department of Health and Human Services, U.S. Department of the Treasury, and U.S. Department of Labor. (December 3, 2018). Reforming America's Healthcare System Through Choice and Competition. Retrieved from https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[5] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, 129 Stat. 128.
[6] Medicare Payment Advisory Commission. (March 15, 2019). March 2019 Report to Congress: Medicare Payment Policy. Retrieved from http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf?sfvrsn=0
[7] Smiley, R.A., Lauer, P., Bienemy, C., Berg, J.G., Shireman, E., Reneau, K.A., & Alexander, M. (October 2018). The 2017 National Nursing Workforce Survey. *Journal of Nursing Regulation*, 9(3), supplement (S1-S54).

In order to achieve truly balanced federal committees, represented interests must include RNs, APRNs, and allied health professionals.

Recommendation: Correct Provider Attestation and Remove "Incident-To" Billing
As CMS seeks to reduce barriers to beneficiaries' access to care and find cost-effective solutions to improve coding and documentation requirements for Medicare and Medicaid payment, AACN recommends correcting provider attestation and removing "incident-to" billing.

Requiring each MIPS-eligible provider to be identified by a unique virtual group participant identifier, Tax Identification Number (TIN), and National Provider Identifier (NPI) would lead to administrative simplification and more accurate attestation of providers caring for patients. These identification numbers can be used in recognizing and eliminating redundancies in the payer system, including "incident-to" billing.

In its June 2019 report to Congress, MedPAC recommends requiring APRNs and PAs to bill directly for services provided, thus eliminating "incident-to" billing. In addition, MedPAC recommends that the Secretary refine specialty designations for APRNs and PAs to give Medicare a greater account of the services provided by these clinicians, thus giving Congress greater ability to target resources toward primary care.[8]

Thank you for considering these comments in response to the *Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020*, file code CMS-1715-P. In order to continue working toward reducing unnecessary burdens for clinicians, providers, patients, and their families, we strongly urge your consideration of the actions outlined in this letter.

Please consider AACN an ally in this endeavor. If our organization can be of any assistance, please contact AACN's Director of Policy, Dr. Colleen Leners at cleners@aacnnursing.org.

Sincerely,

Deborah E. Trautman

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President and Chief Executive Officer

[8] Medicare Payment Advisory Commission. (June 14, 2019). Report to Congress: Medicare and the Health Care Delivery System. Retrieved from http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0