American Association
of Colleges of Nursing

September 29, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2021 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; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

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 2021, file code CMS-1734-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' continued efforts to reduce restrictive and unnecessary regulatory burdens and eliminate wasteful Medicare expenditures, while increasing patient access to affordable, high-quality care. We appreciate the opportunity to provide comment on proposed rules that specifically eliminate regulations currently hindering healthcare delivery by impeding highly qualified clinicians' scopes of practice.

[1] *2019-2020 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC: American Association of Colleges of Nursing.

AACN applauds CMS for its efforts to be flexible in addressing the pressing needs of the American people during the public health emergency (PHE) posed by the COVID-19 pandemic.

AACN offers the following recommendations to improve upon proposed changes in the 2021 Medicare Physician Fee Schedule proposed rule and will address each in turn:

- Continue reducing barriers and increasing access to telehealth;
- Include CRNAs among list of providers who can supervise diagnostic tests;
- Ensure the Quality Payment Programs encourages and supports clinical preceptors for all healthcare education;
- Recommend immediate implementation of Section 5 of EO 13890, which should nullify the need for "incident-to" billing for APRNs and non-physician providers;
- Adopt provider-neutral language in all regulatory interpretations of the law, where appropriate; and
- Amend statutory language to ensure that health-related federal committees and boards reflect diverse representation of the health workforce.

Recommendation: Continue Reducing Barriers and Increasing Access to Telehealth

We strongly support making all telehealth flexibilities afforded during the PHE permanent. We recognize the pandemic restricted the availability of personal protective equipment (PPE), which significantly impacted nursing students' ability to complete their required clinical hours. As telehealth technology allows increased flexibility and access for patients, it can also be utilized to satisfy some of the direct nursing clinical hours required by state boards of nursing, thereby ensuring schools of nursing are able to continue meeting the needs of the healthcare system now and in the future.[2] Schools of nursing have been encouraged to develop contingency plans should future restrictions on clinical placements occur due to safety concerns for the students. These plans may include the expanded use of simulation, telehealth, and virtual reality in keeping with best practices and guidelines from state boards of nursing.

Recommendation: Include CRNAs Among List of Providers who Can Supervise Diagnostic Tests

AACN commends CMS for including CRNAs in the list of APRN providers who can review and verify student E/M documentation. The current proposal would allow NPs, CNSs, physician assistants (PAs), and CNMs to supervise the performance of diagnostic tests in addition to physicians. AACN also supports CRNAs' inclusion on the list of providers that can supervise the performance of diagnostic tests. It is essential that CRNAs be added considering 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.

Recommendation: Ensure the Quality Payment Program Encourages and Supports Clinical Preceptors for all Health Care Education

[2] "Considerations for COVID-19 Preparedness and Response in U.S. Schools of NursingAmerican Association of Colleges of Nursing, www.aacnnursing.org/News-Information/COVID-19/AACN-Recommendations.

In 2017, CMS requested comments on updates to the quality payment program (QPP). At that time, CMS recognized the need for a strong education component in the clinical practice setting in its proposal titled *"Providing Education Opportunities for New Clinicians."* CMS acknowledged the severity of the clinical training site shortages when it proposed this important step to improve this challenging hurdle.[3] Now, more than ever, due to the COVID-19 pandemic, this issue has been brought to the forefront as we train the next generation of healthcare heroes. The proposed improvement activity would grant credit to clinicians who serve as preceptors for students while participating in the Merit-Based Incentive Payment System (MIPS).CMS has recognized that serving as a preceptor has a significant impact on beneficiary care, safety, health, and wellbeing, and exposes learners to high-quality, value-based practices.[4] We suggest that CMS revisit this QPP initiative, establishing a foundation to prepare quality clinicians for the future of America's health care.

Recommendation: Immediate implementation of Section 5 of EO 13890, which should nullify the need for "incident-to" billing for APRNs and non-physician providers

The 2021 PFS proposed rule reflects a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation. The Administration's findings from the report, *"Reforming America's Healthcare System Through Choice and Competition"* recommended "reforming the scope of practice laws to allow all healthcare providers to practice to the top of their license, utilizing their full skill set." [5]

AACN also supports allowing all providers to practice to the full extent of their education and training. AACN supports the immediate implementation of section 5 of EO 13890 on *"Protecting and Improving Medicare for Our Nation's Seniors"* and encourages CMS to continue to remove Medicare barriers on APRNs and their patients that are more stringent than Federal and State law require. The Secretary should implement the proposed reforms to "ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician's occupation." [6] With the implementation of Section 5 of the EO 13890, this should nullify the need for "incident-to" billing for APRNs and non-physician providers.

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The Medicare Payment Advisory Commission (MedPAC), in its June 2019 report to Congress, 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, giving Congress the ability to target resources toward primary care.[7]

Recommendation: Adopt Provider-Neutral Language

[3] Forsberg I, Swartout K, et. al (2014). Nurse Practitioner Education: Greater Demand Reduced Training Opportunities. Journal of the American Association of Nurse Practitioners, 2014. doi: 10.1002/2327- National and
[4] Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. https://bhw.hrsa.gov/sites/default/files/bhw
[5] 2018, pp. 36, Reforming America's Healthcare System Through Choice and Competition.
[6] United States, Executive Office of the President [Donald Trump]. Executive order 13890: Protecting and Improving Medicare for Our Nation's Seniors 3 CRF 13890
[7] 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

AACN requests use of provider-neutral language in all regulatory rulemaking. The December 2018 HHS report titled "*Reforming America's Healthcare System through Choice and Competition*" and the Medicare Access and CHIP Reauthorization Act (MACRA) (H.R. 2, Pub. L. 114-10) both defined the MIPS-eligible professionals to include physicians, PAs, NPs, CNSs, and CRNAs.[8,9] According to the March 2019 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.[10]

Healthcare 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. CMS should update all regulatory language to reflect the full spectrum of healthcare 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 their 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."

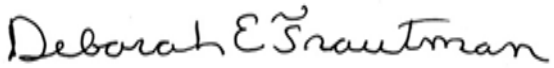
In recognition of this mandate, AACN strongly recommends amending the language in the FACA Membership Balance Plan to hold each health-related federal committee responsible for ensuring that appointed members proportionately reflect the diverse representation of the health workforce. Nursing is the nation's largest healthcare profession, with more than 3.8 million RNs nationwide.[11] And yet, we note that physicians account for over half of the membership across many health-related federal advisory committees, task forces, and boards. In order to achieve truly balanced committees, represented interests must include registered RNs, APRNs, and allied health professionals.

Thank you for considering these comments in response to the proposed revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021. 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.

[8] 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
[9] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, 129 Stat. 128.
[10] 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
[11] 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).

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 or AACN's Policy Assistant, Emily Turek at eturek@aacnnursing.org.

Sincerely,



Deborah E. Trautman, PhD, RN, FAAN
President and Chief Executive Officer